

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06863

CERTIFICATE OF DEATH

06856

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Please remove carbon papers. Page 2 and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Dorchester		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Cambridge		c. LENGTH OF STAY IN 1b 1 yr. 9 mos. 8 days						
d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Eastern Shore State Hospital		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						
3. NAME OF DECEASED (Type or print) Ollie Howard Brinsfield		First Ollie	Middle Howard					
4. DATE OF DEATH 05-22-1966		Last Brinsfield	Month 05					
5. SEX Male		6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED					
8. DATE OF BIRTH 10-29-86		9. AGE (In years last birthday) 79 yrs.						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY						
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA						
13. FATHER'S NAME Daniel Brinsfield		14. MOTHER'S MAIDEN NAME Cleo Harvey						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. UNKNOWN						
17. INFORMANT Medical Records Address Easter Shore State Hospital		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia, bldst. DUE TO 177X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. { (b) Carcinoma of prostate with DUE TO { (c) widespread metastases						
INTERVAL BETWEEN ONSET AND DEATH								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)						
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) 5/22	(County) 1966	(State) MD		
21. I certify that (I) (this hospital) attended the deceased from 5/22 , 1966, to 5/22 , 1966, that (I) (we) last saw the deceased alive on 5/22 , 1966, and that death occurred at 177X , M, from causes and on the date stated above.				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
22a. SIGNATURE Dr. W. K. Siegel		M.D. <input checked="" type="checkbox"/> ATTENDING PHYS.		MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 5-23-66		
22c. PHYSICIAN'S NAME (Type) W. K. Siegel		22d. ADDRESS E. New Market, Md						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/23/66		23c. NAME OF CEMETERY OR CREMATORIAL Vienna		23d. LOCATION (City or Town) Vienna	(County) Md	(State)
24. FUNERAL DIRECTOR Charles Milligan		ADDRESS East New Market		25a. REC'D BY REGISTRAR MAY 31 1966		25b. REGISTRAR'S SIGNATURE Charles Judge		

87-210

1980-10-31 1980

63000

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66	67	68	69	70	71	72	73	74	75	76	77	78	79	80	81	82	83	84	85	86	87	88	89	90	91	92	93	94	95	96	97	98	99	100	101	102	103	104	105	106	107	108	109	110	111	112	113	114	115	116	117	118	119	120	121	122	123	124	125	126	127	128	129	130	131	132	133	134	135	136	137	138	139	140	141	142	143	144	145	146	147	148	149	150	151	152	153	154	155	156	157	158	159	160	161	162	163	164	165	166	167	168	169	170	171	172	173	174	175	176	177	178	179	180	181	182	183	184	185	186	187	188	189	190	191	192	193	194	195	196	197	198	199	200	201	202	203	204	205	206	207	208	209	210	211	212	213	214	215	216	217	218	219	220	221	222	223	224	225	226	227	228	229	230	231	232	233	234	235	236	237	238	239	240	241	242	243	244	245	246	247	248	249	250	251	252	253	254	255	256	257	258	259	260	261	262	263	264	265	266	267	268	269	270	271	272	273	274	275	276	277	278	279	280	281	282	283	284	285	286	287	288	289	290	291	292	293	294	295	296	297	298	299	300	301	302	303	304	305	306	307	308	309	310	311	312	313	314	315	316	317	318	319	320	321	322	323	324	325	326	327	328	329	330	331	332	333	334	335	336	337	338	339	340	341	342	343	344	345	346	347	348	349	350	351	352	353	354	355	356	357	358	359	360	361	362	363	364	365	366	367	368	369	370	371	372	373	374	375	376	377	378	379	380	381	382	383	384	385	386	387	388	389	390	391	392	393	394	395	396	397	398	399	400	401	402	403	404	405	406	407	408	409	410	411	412	413	414	415	416	417	418	419	420	421	422	423	424	425	426	427	428	429	430	431	432	433	434	435	436	437	438	439	440	441	442	443	444	445	446	447	448	449	450	451	452	453	454	455	456	457	458	459	460	461	462	463	464	465	466	467	468	469	470	471	472	473	474	475	476	477	478	479	480	481	482	483	484	485	486	487	488	489	490	491	492	493	494	495	496	497	498	499	500	501	502	503	504	505	506	507	508	509	510	511	512	513	514	515	516	517	518	519	520	521	522	523	524	525	526	527	528	529	530	531	532	533	534	535	536	537	538	539	540	541	542	543	544	545	546	547	548	549	550	551	552	553	554	555	556	557	558	559	560	561	562	563	564	565	566	567	568	569	570	571	572	573	574	575	576	577	578	579	580	581	582	583	584	585	586	587	588	589	590	591	592	593	594	595	596	597	598	599	600	601	602	603	604	605	606	607	608	609	610	611	612	613	614	615	616	617	618	619	620	621	622	623	624	625	626	627	628	629	630	631	632	633	634	635	636	637	638	639	640	641	642	643	644	645	646	647	648	649	650	651	652	653	654	655	656	657	658	659	660	661	662	663	664	665	666	667	668	669	670	671	672	673	674	675	676	677	678	679	680	681	682	683	684	685	686	687	688	689	690	691	692	693	694	695	696	697	698	699	700	701	702	703	704	705	706	707	708	709	710	711	712	713	714	715	716	717	718	719	720	721	722	723	724	725	726	727	728	729	730	731	732	733	734	735	736	737	738	739	740	741	742	743	744	745	746	747	748	749	750	751	752	753	754	755	756	757	758	759	760	761	762	763	764	765	766	767	768	769	770	771	772	773	774	775	776	777	778	779	780	781	782	783	784	785	786	787	788	789	790	791	792	793	794	795	796	797	798	799	800	801	802	803	804	805	806	807	808	809	8010	8011	8012	8013	8014	8015	8016	8017	8018	8019	8020	8021	8022	8023	8024	8025	8026	8027	8028	8029	8030	8031	8032	8033	8034	8035	8036	8037	8038	8039	8040	8041	8042	8043	8044	8045	8046	8047	8048	8049	8050	8051	8052	8053	8054	8055	8056	8057	8058	8059	8060	8061	8062	8063	8064	8065	8066	8067	8068	8069	8070	8071	8072	8073	8074	8075	8076	8077	8078	8079	8080	8081	8082	8083	8084	8085	8086	8087	8088	8089	8090	8091	8092	8093	8094	8095	8096	8097	8098	8099	80100	80101	80102	80103	80104	80105	80106	80107	80108	80109	80110	80111	80112	80113	80114	80115	80116	80117	80118	80119	80120	80121	80122	80123	80124	80125	80126	80127	80128	80129	80130	80131	80132	80133	80134	80135	80136	80137	80138	80139	80140	80141	80142	80143	80144	80145	80146	80147	80148	80149	80150	80151	80152	80153	80154	80155	80156	80157	80158	80159	80160	80161	80162	80163	80164	80165	80166	80167	80168	80169	80170	80171	80172	80173	80174	80175	80176	80177	80178	80179	80180	80181	80182	80183	80184	80185	80186	80187	80188	80189	80190	80191	80192	80193	80194	80195	80196	80197	80198	80199	80200	80201	80202	80203	80204	80205	80206	80207	80208	80209	80210	80211	80212	80213	80214	80215	80216	80217	80218	80219	80220	80221	80222	80223	80224	80225	80226	80227	80228	80229	80230	80231	80232	80233	80234	80235	80236	80237	80238	80239	80240	80241	80242	80243	80244	80245	80246	80247	80248	80249	80250	80251	80252	80253	80254	80255	80256	80257	80258	80259	80260	80261	80262	80263	80264	80265	80266	80267	80268	80269	80270	80271	80272	80273	80274	80275	80276	80277	80278	80279	80280	80281	80282	80283	80284	80285	80286	80287	80288	80289	80290	80291	80292	80293	80294	80295	80296	80297	80298	80299	80300	80301	80302	80303	80304	80305	80306	80307	80308	80309	80310	80311	80312	80313	80314	80315	80316	80317	80318	80319	80320	80321	80322	80323	80324	80325	80326	80327	80328	80329	80330	80331	80332	80333	80334	80335	80336	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1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 24 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 7 Film G377 6/6/66

1. PLACE OF DEATH a. COUNTY Dorchester		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN lb Life		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland		b. COUNTY Dorchester	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) DOA Cambridge Maryland Hospital		e. STREET ADDRESS 209 Byrn Street		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) LEVIN EDWARD BROMWELL		First	Middle	Last	4. DATE OF DEATH May 29	Month	Day	Year 1966	
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 21, 1902		9. AGE (In years last birthday) 63 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maintenance		10b. KIND OF BUSINESS OR INDUSTRY City Public Works		11. BIRTHPLACE (State or foreign country) Cambridge, Maryland		12. CITIZEN OF WHAT COUNTRY USA			
13. FATHER'S NAME Levin Edward Bromwell		14. MOTHER'S MAIDEN NAME Susan Clark							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) No		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Mrs. Ira Saunders, Madison, Maryland		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH 30 Mins.							
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a)		Cerebral vascular accident							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 331X									
DUE TO (b)									
DUE TO (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a.m. p.m. 19		Month, Day, Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE John Ace Jr. M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>							
EXAMINER'S NAME (Type)		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>							
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 5/31/66							
Address (Street, city, town, or county) Cambridge, Md.									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 31, 1966	22c. NAME OF CEMETERY OR CREMATORIAL Christ Church Cemetery	22d. LOCATION (City, town, or county) Cambridge, Maryland		(State)			
23. FUNERAL DIRECTOR LeCompte Funeral Service, Cambridge, Maryland		ADDRESS JUN 2 1966							
		REC'D BY REGISTRAR Charles Judge							
		REGISTRAR'S SIGNATURE							

1994 APR 202

Indigo off northern California

as per

10 INVESTIGATE LEVEL

2000 10 min

30 min

All

Indigo, numbered site, airport WO CONNIE

10 min

Indigo, numbered site

10 min

Indigo, numbered site, airport WO CONNIE

10 min

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

06865

CERTIFICATE OF DEATH

06858

1. PLACE OF DEATH
a. COUNTY

DORCHESTER MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

HURLOCK

c. LENGTH OF STAY IN 1b

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

BELLE HAVEN NURSING HOME

3. NAME OF
DECEASED
(Type or print)

First

Middle

Last

4. DATE
OF
DEATH

Month

Day

Year

5. SEX

6. COLOR OR RACE

F. W.

7. MARRIED NEVER MARRIED

WIDOWED DIVORCED

8. DATE OF BIRTH

1-24-1882

9. AGE (In years
last birthday)

84 yrs.

10. IF UNDER 1 YEAR

Months Days Hours Min.

11. IF UNDER 24 HRS.

10a. USUAL OCCUPATION (Give kind of work done
during most of working life, even if retired)

HOUSEWIFE

10b. KIND OF BUSINESS OR
INDUSTRY

NONE

11. BIRTHPLACE (County & State, or foreign country)

Penna.

12. CITIZEN OF WHAT
COUNTRY?

U.S.A.

13. FATHER'S NAME

ADAM YOH

14. MOTHER'S MAIDEN NAME

NO RECORD

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give war or dates of service)

No

16. SOCIAL SECURITY NO.

Unknown

17. INFORMANT

Address
Blake E. Brooks Lenton, Md.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

4200

ventricular fibrillation

INTERVAL BETWEEN
ONSET AND DEATH
minutes

Conditions, If any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

DUE TO

(b)

OUE TO

(c)

arteriosclerotic heart disease

5 years.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY
PERFORMED?

YES ND

20a. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour a.m.
p.m. 19

20d. INJURY OCCURRED
While at work Not While at work

20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town) (County) (State)
Hurstlock, Md. Anne Arundel County Maryland

21. I certify that (I) (this hospital) attended the deceased from March 30, 1966, to May 21, 1966, that (I) (we) last saw the deceased alive on May 21, 1966, and that death occurred at 6:30 A.M., from the causes and on the date stated above.

22a. SIGNATURE

Carlos F. Barroso

M.O. ATTENDING
PHYS.

M.D.
DIRECTOR STAFF
PHYS.

22b. DATE SIGNED

5-24-1966

22c. PHYSICIAN'S
NAME (Type)

Carlos F. Barroso

22d. ADDRESS

Hurstlock Medical Center, Hurstlock, Md.

23a. BURIAL, CREMATION,
REMDVAL (Specify)

Burial

23b. DATE THEREOF

5-26-66

23c. NAME OF CEMETERY OR CREMATORIUM

Greensboro

23d. LOCATION (City, town or county) (State)

Greensboro, Md.

24. FUNERAL DIRECTOR

J. E. Boulaire

ADDRESS

Greensboro, Md.

25a. REC'D BY REGISTRAR

MAY 26 1966

25b. REGISTRAR'S SIGNATURE

Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

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Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

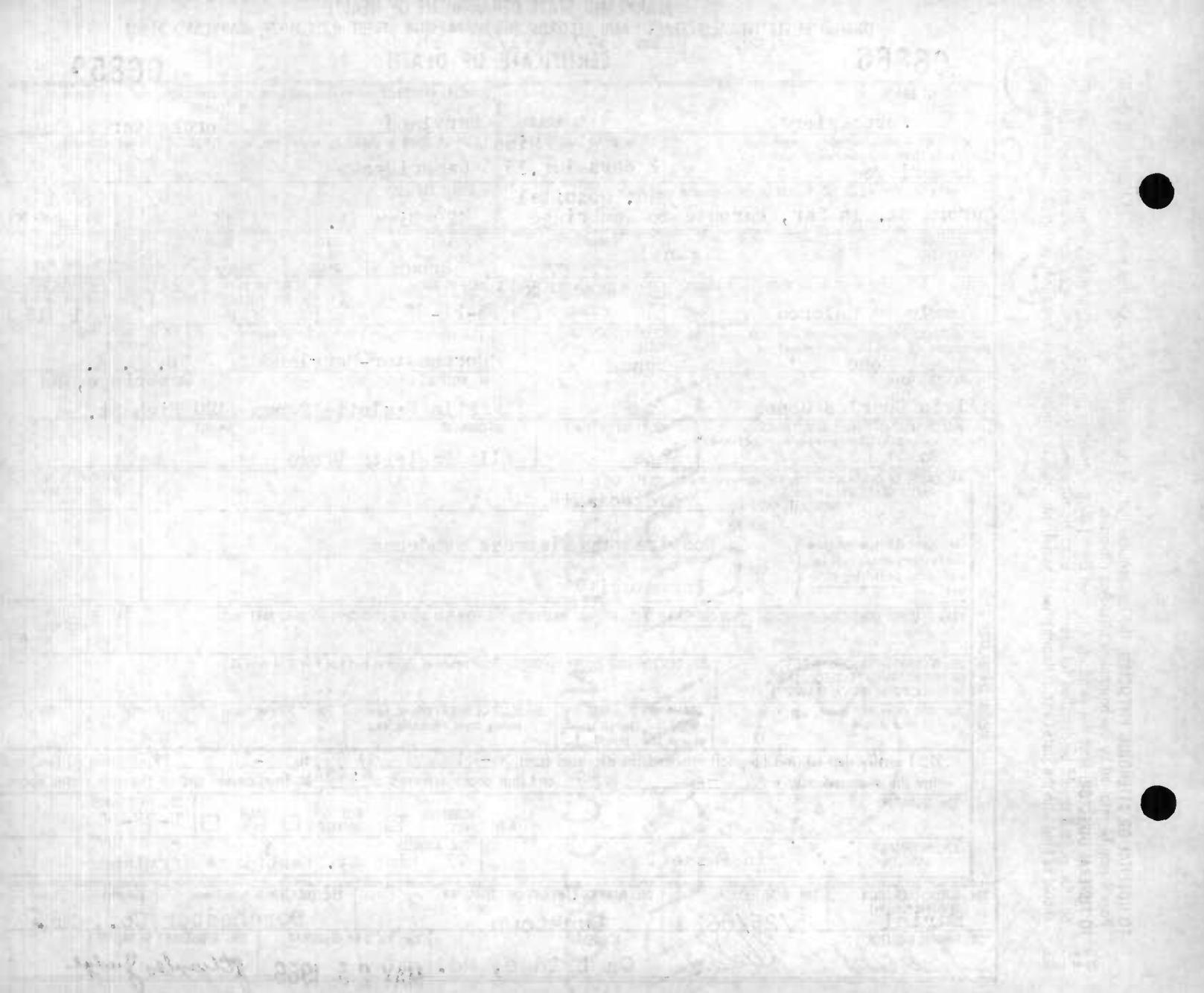
06866

Item 3 Film G377 6/1/66 mh

CERTIFICATE OF DEATH

06859

1. PLACE OF DEATH a. COUNTY Dorchester		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		b. COUNTY Dorchester	
c. LENGTH OF STAY IN 5ins 2 days 1Hr. 15		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Md. Hospital Aurora St. In Car, enroute to Cambridge		d. STREET ADDRESS 420 High St.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Twin I	Middle L	4. DATE OF DEATH Month May Day 23 Year 1966
S. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-21-66
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (County & State, or foreign country) Dorchester-Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Alvin Charles Jones		14. MOTHER'S MAIDEN NAME Ella Paulette Brown 420 High St.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Ella Paulette Brown		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Atetectasis 7625 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Respiratory distress syndrome DUE TO (c) Prematurity			
INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 5-21 , 19 66 to 5-23 , 19 66 , that (I) (we) last saw the deceased alive on 5-23 , 19 66 , and that death occurred at 6:45A M, from causes and on the date stated above.			
22a. SIGNATURE <i>Edwin Fassett</i>		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 5-23-66
22c. PHYSICIAN'S NAME (Type) Dr J Edwin Fassett		22d. ADDRESS 727 Pine St. Cambridge Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 5/25/66	23c. NAME OF CEMETERY OR CREMATORIAL Bucktown	23d. LOCATION (City or Town) (County) (State) Dorchester Co. Md.
24. FUNERAL DIRECTOR <i>Juliet C. Judge</i>	ADDRESS Cambridge, Md.	25a. REC'D BY REGISTRAR MAY 25 1966	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

06866

CERTIFICATE OF DEATH

06860

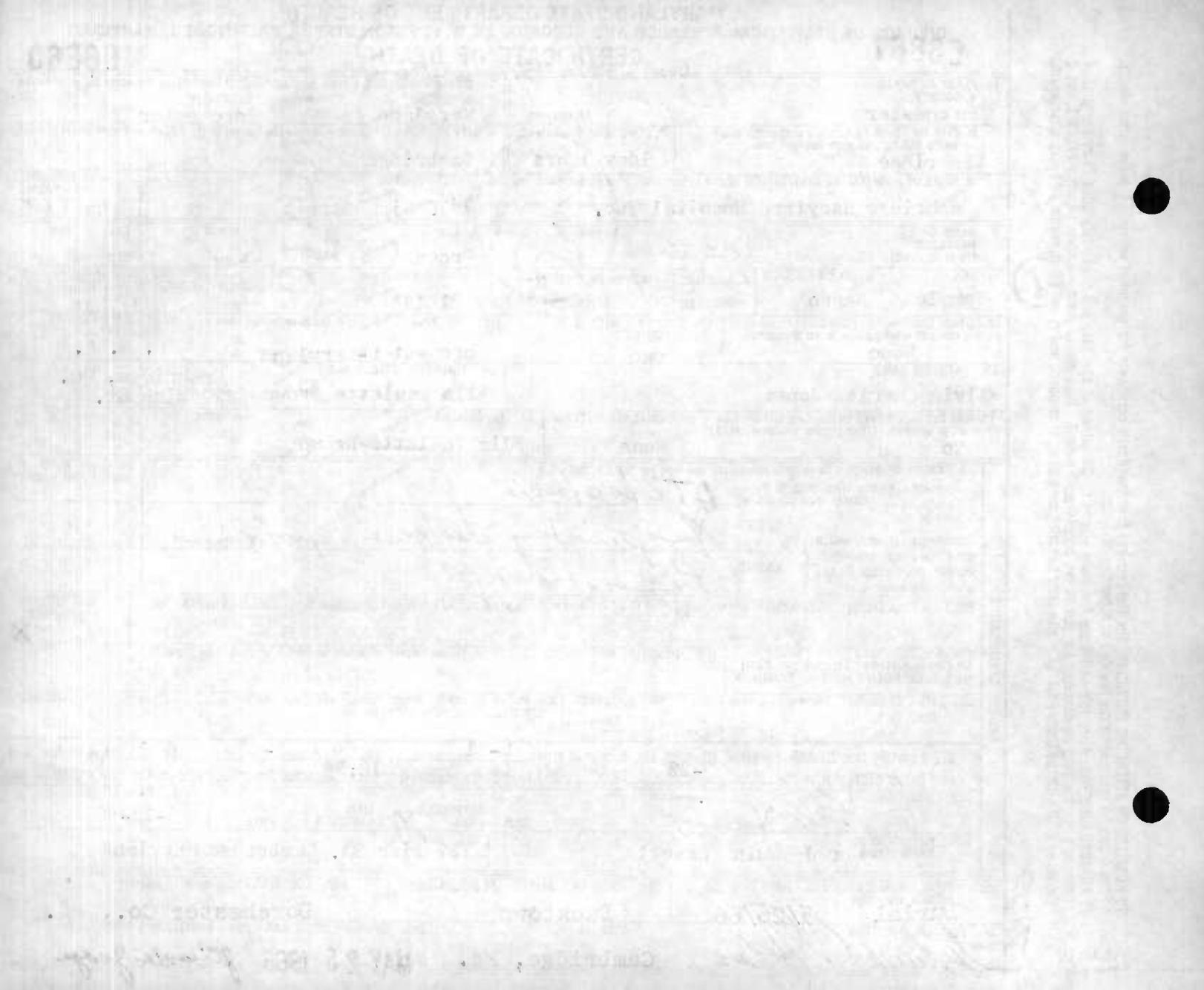
Item 3 Film G372 6/17/66 mh

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
 Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

1. PLACE OF DEATH a. COUNTY Dorchester		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN 1b 1day 19hrs	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Cambridge Maryland Hospital Inc.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Twin II	Middle 	Last Brown
4. DATE OF DEATH May 23 1966	Month May	Day 23	Year 1966
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 21 1966
10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	9. AGE (In year's last birthday) yrs. 1
13. FATHER'S NAME Alvin Charles Jones		11. BIRTHPLACE (County & State, or foreign country) Dorchester-Maryland	12. CITIZEN OF WHAT COUNTRY? U. S. A.
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) No		16. SOCIAL SECURITY NO. None	17. INFORMANT Ella Paulette Brown
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) osteopetrosis 7625 DUE TO Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last. } (b) respiratory distress syndrome DUE TO (c) hypoxia PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)			
INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 5-21 1966 to 5-23 1966 , that (I) (we) last saw the deceased alive on 5-22 1966 , and that death occurred at 12:58 P.M. from the causes and on the date stated above.			
22a. SIGNATURE <i>J. Edwin Fassett</i>		22b. DATE SIGNED 5-23-66	
22c. PHYSICIAN'S NAME (Type) Dr J Edwin Fassett		22d. ADDRESS 727 Pine St. Cambridge Maryland	

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 5/26/66	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Bucktown	23d. LOCATION (City, town or county) (State) Dorchester Co. Md.
24. FUNERAL DIRECTOR <i>J. Edwin Fassett</i>	25a. REC'D BY REGISTRAR 	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	
DATE MAY 25 1966		DAY	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 M

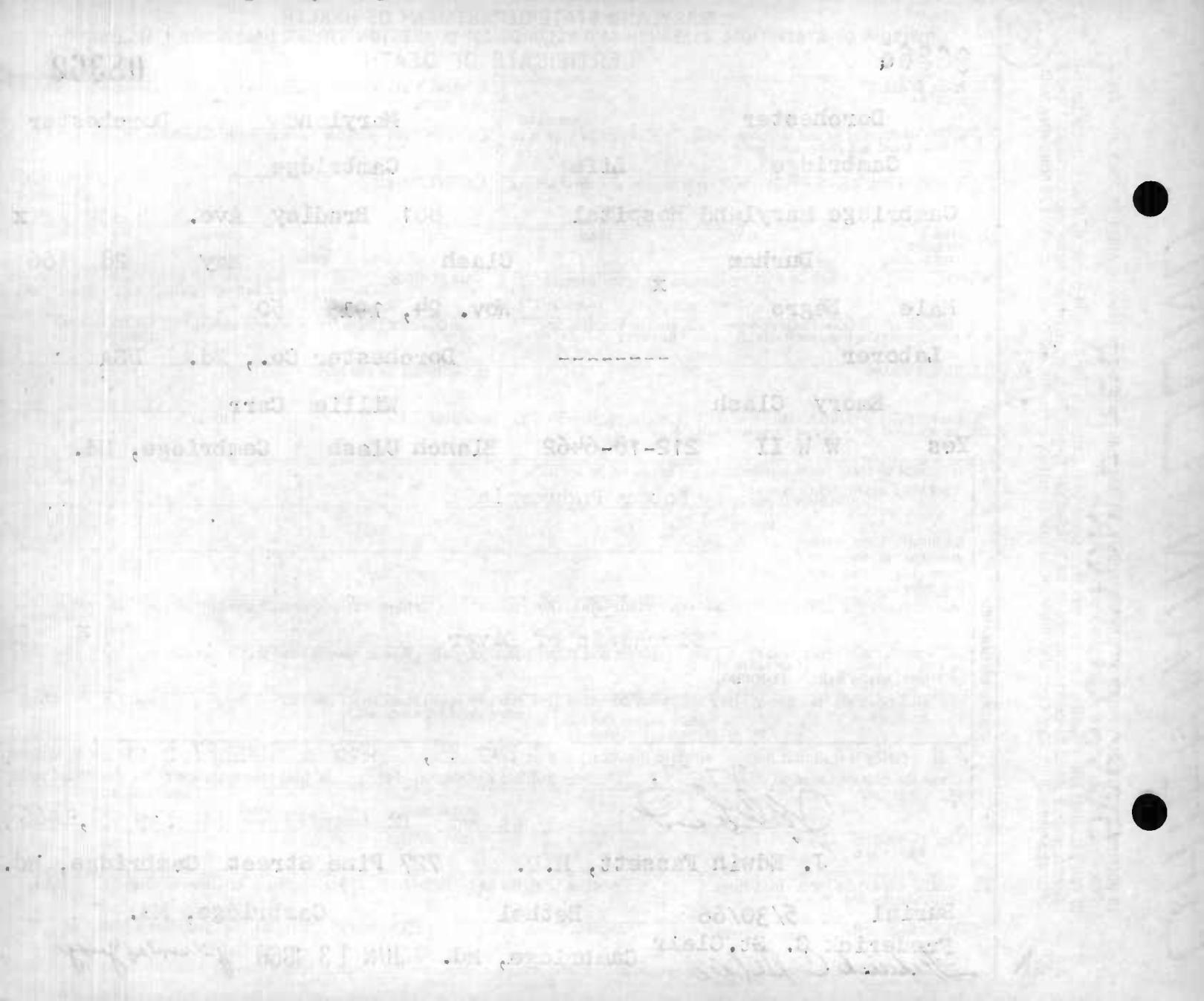
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

06863

08362

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN 1b Life		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Cambridge Maryland Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)	First Durham	Middle Clash	Last May 28 1966	
4. DATE OF DEATH Month May	Day 28	Year 1966		
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 24, 1915	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer	10b. KIND OF BUSINESS OR INDUSTRY -----	11. BIRTHPLACE (County & State, or foreign country) Dorchester Co., Md.	12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Emory Clash	14. MOTHER'S MAIDEN NAME Willie Carr	Address		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes	16. SOCIAL SECURITY NO. W W II 212-18-6462	17. INFORMANT Blanch Clash	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lobar Pneumonia 490X Ccnditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) (c) DUE TO DUE TO DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Cirrhosis of Liver	INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from May 25, 1966 , to May 27, 1966 that (I) (we) last saw the deceased alive on May 27, 1966 , and that death occurred at M , from the causes and on the date stated above.	22a. SIGNATURE <i>J. Edwin Fassett</i>	22b. DATE SIGNED May 28, 1966		
22c. PHYSICIAN'S NAME (Type) J. Edwin Fassett, M.D.	22d. ADDRESS 727 Pine Street Cambridge, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 5/30/66	23c. NAME OF CEMETERY OR CREMATORIAL Bethel	23d. LOCATION (City, town or county) (State) Cambridge, Md.	
24. FUNERAL DIRECTOR Frederick C. St. Clair	ADDRESS Julius E. Oliver	25a. REC'D BY REGISTRAR JUN 13 1966	25b. REGISTRAR'S SIGNATURE Charles Judge	



FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

06869

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06861

1. PLACE OF DEATH e. COUNTY Dorchester MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) e. STATE Maryland b. COUNTY Dorchester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Cambridge		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Cambridge	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) R.F.D. 2		d. STREET ADDRESS R.R.D. 2	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Veatrice	Middle H.	Last Clash
4. DATE OF DEATH	Month May	Day 18	Year 66 19
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH Feb. 26, 1904	9. AGE (In years last birthday) 62 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Hours 0
10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer	10b. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Charles Payton	14. MOTHER'S MAIDEN NAME Harrett McNamara		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. 220-01-8931	17. INFORMANT Melvin Clash	Address RFD 2 Cambridge, Md.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 4201 Conditions, If any, which give rise to immediate cause (a), stating the underlying cause last. (b) (c) DUE TO DUE TO DUE TO			
INTERVAL BETWEEN ONSET AND DEATH Instant			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)			
20e. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) John Mace Jr. M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) Cambridge, Md.	
22. DATE SIGNED 5/27/66			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 5/22/66	23c. NAME OF CEMETERY OR CREMATORIUM Bethel Cemetery	23d. LOCATION (City, town or county) (State) Cambridge, Dor. Md.
24. FUNERAL DIRECTOR StClair Funeral Service	ADDRESS Cambridge, Md.	25a. REC'D BY REGISTRAR DATE MAY 31 1966	25b. REGISTRAR'S SIGNATURE j Charles Judge

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form M-10. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Film #377- 6/16/66. M.B.

Originally reported on regular death
certificate instead of M.E.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

06870

CERTIFICATE OF DEATH

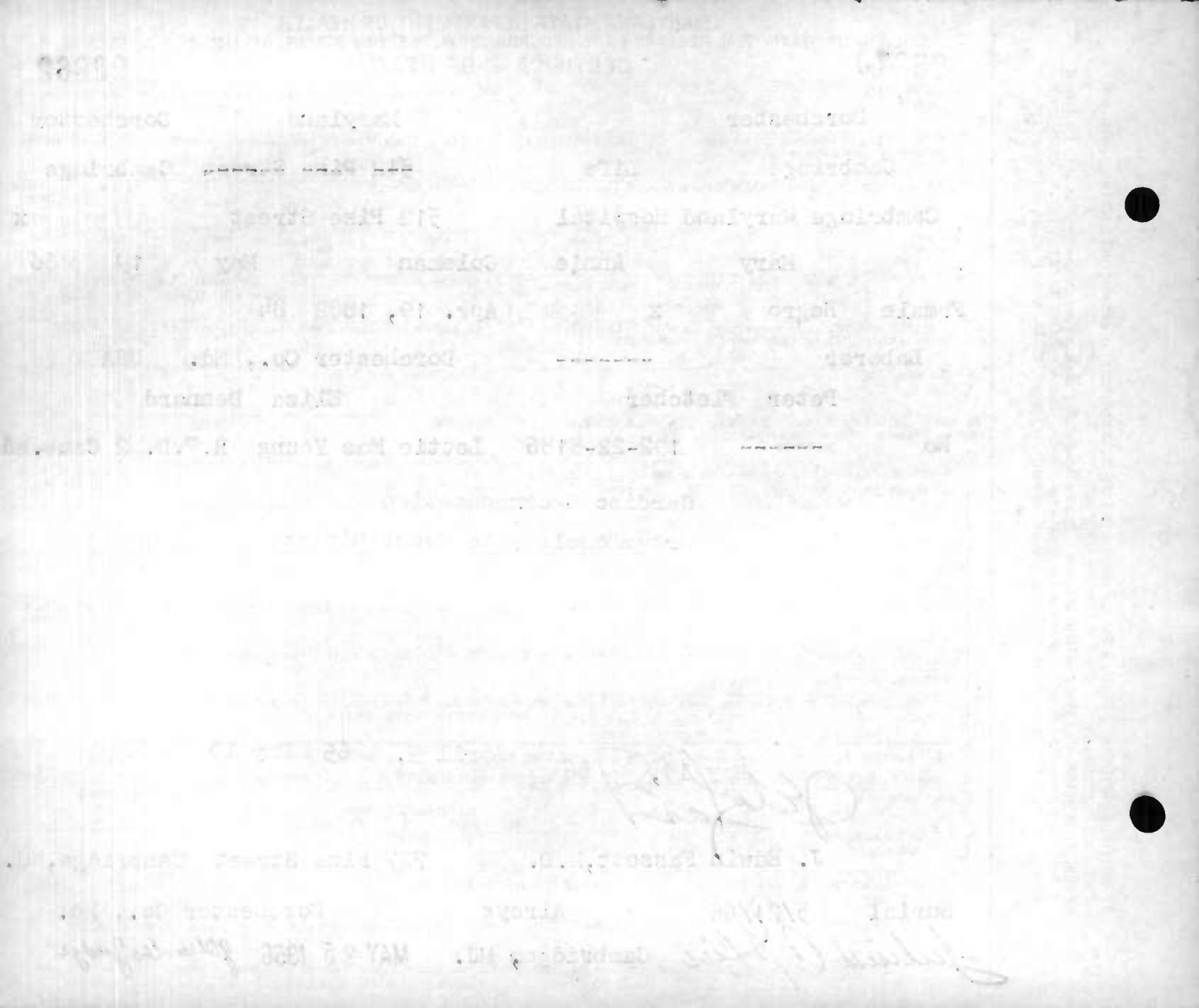
06862

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
 Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Dorchester		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland		b. COUNTY Dorchester			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN 1b Life		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 542 Pine Street Cambridge		d. STREET ADDRESS 512 Pine Street			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Cambridge Maryland Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Mary		First	Middle	Last	4. DATE OF DEATH May 19 1966	Month	Day	Year	
5. SEX Female		6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Apr. 19, 1882	9. AGE (in years last birthday) 84 yrs.	IF UNDER 1 YEAR Months	Days	Hours	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (County & State, or foreign country) Dorchester Co., Md.		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Peter Fletcher		14. MOTHER'S MAIDEN NAME Eliza Dennard							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. -----		17. INFORMANT 192-22-8186 Lettie Mae Young R.F.D. 2 Camb. Md.		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		INTERVAL BETWEEN ONSET AND DEATH Cardiac Decompensation							
4200 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO (b)	Arteriosclerotic Heart Disease						
		DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from April 5, 1965 to May 19, 1966 , that (I) (we) last saw the deceased alive on May 19, 1966 , and that death occurred at M , from the causes and on the date stated above.									
22a. SIGNATURE <i>Peter Fletcher</i>		22b. DATE SIGNED							
22c. PHYSICIAN'S NAME (Type) J. Edwin Fassett, M.D.		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS 727 Pine Street Cambridge, Md.							

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/21/66	23c. NAME OF CEMETERY OR CREMATORIAL Aireys	23d. LOCATION (City, town or county) (State) Dorchester Co., Md.	
24. FUNERAL DIRECTOR <i>Julie C. Fassett</i>		ADDRESS Cambridge, Md.	25a. REC'D BY REGISTRAR MAY 25 1966	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



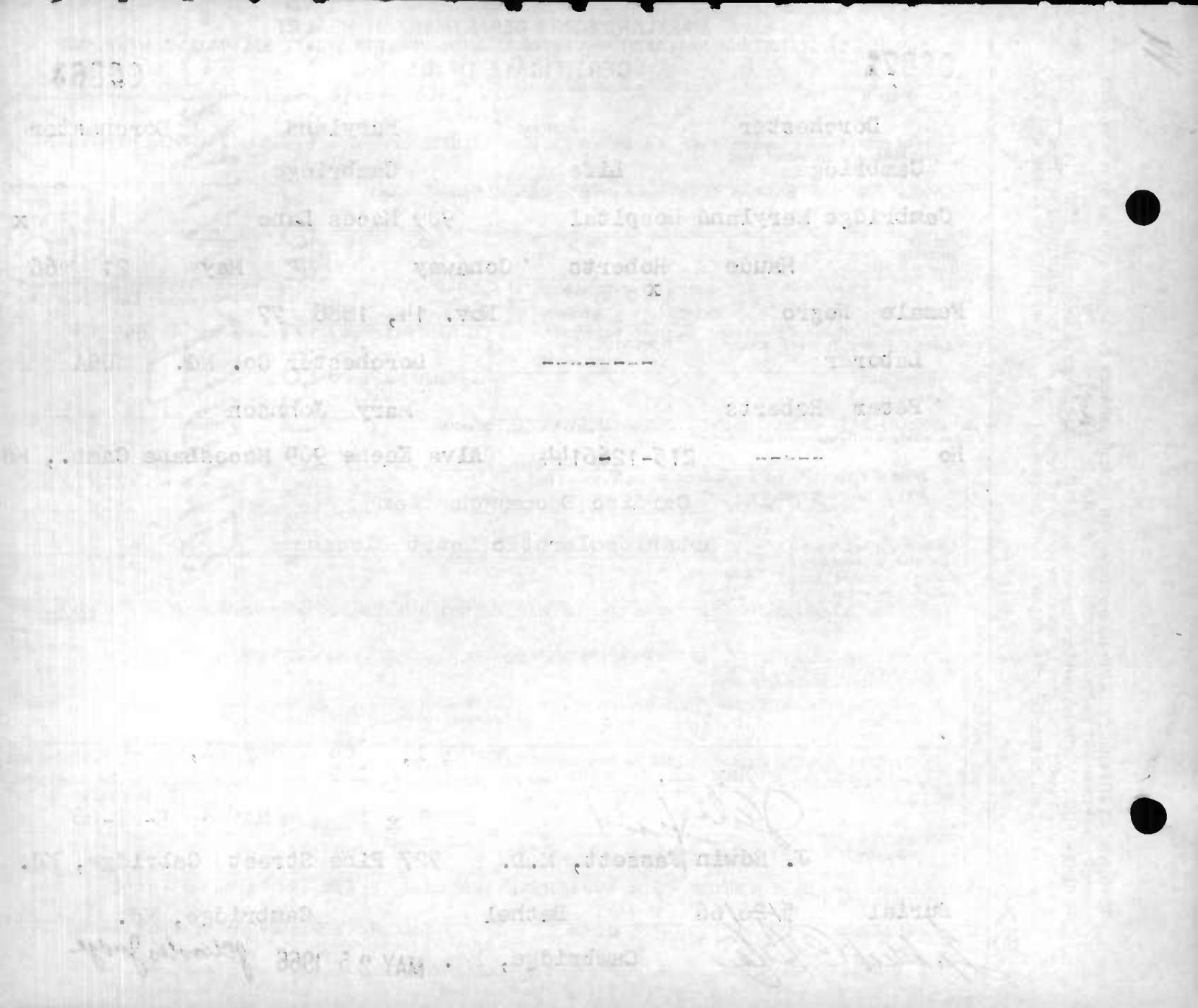
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Dorchester		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		b. COUNTY Dorchester		
c. LENGTH OF STAY IN 1b Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Cambridge Maryland Hospital		d. STREET ADDRESS 909 Maces Lane		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First Maude	Middle Roberts	Last Conaway	
4. DATE OF DEATH	Month May	Day 21	Year 1966	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 14, 1888	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer	10b. KIND OF BUSINESS OR INDUSTRY -----	11. BIRTHPLACE (County & State, or foreign country) Dorchester Co. Md.	12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Peter Roberts	14. MOTHER'S MAIDEN NAME Mary Johnson	Address Alva Keene 909 MacesLane Camb., Md		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. 215-1266144	17. INFORMANT	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4200 Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last. DUE TO (b) Arteriosclerotic Heart Disease DUE TO (c)	INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from April 1, 1966 , to May 21, 1966 , that (I) (we) last saw the deceased alive on May 21, 1966 , and that death occurred at 12P.M. , from the causes and on the date stated above.				
22a. SIGNATURE <i>J. Edwin Fassett</i>	22b. DATE SIGNED 5-21-66			
22c. PHYSICIAN'S NAME (Type) J. Edwin Fassett, M.D.	22d. ADDRESS 727 Pine Street Cambridge, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 5/26/66	23c. NAME OF CEMETERY OR CREMATORIUM Bethel	23d. LOCATION (City, town or county) (State) Cambridge, Md.	
24. FUNERAL DIRECTOR <i>Julian C. Fassett</i>	ADDRESS Cambridge, Md.	25a. REC'D BY REGISTRAR MAY 25 1966	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



1 M

FOR STATE
HEALTH DEPT.MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

06872

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06864

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM43. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Dorchester		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE New Jersey		b. COUNTY Warren		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN lb 3 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hackettstown		d. STREET ADDRESS 67-3		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Glasgow Nursing Home						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Jennie E Craig		First Jennie	Middle E	Last Craig	4. DATE OF DEATH May 21 1966	Month May	Day 21	Year 1966
5. SEX F	6. COLOR OR RACE White	7. MARRIED WIDOWED <input checked="" type="checkbox"/> Widowed	NEVER MARRIED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 6 1875	9. AGE (In years last birthday) 90 yrs.	10. UNDER 1 YEAR Months 80	11. UNDER 24 HRS. Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home		11. BIRTHPLACE (State or foreign country) New Jersey		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME John Matthews		14. MOTHER'S MAIDEN NAME Martha Price						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. - - -		17. INFORMANT Records Glasgow Nursing Home, Cambridge		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary embolus						INTERVAL BETWEEN ONSET AND DEATH Instant		
9367 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Fracture neck femur		DUE TO (b) Fracture neck femur				4 weeks		
(c)		DUE TO (c)						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) Pushed to floor by another patient.						
20c. TIME OF INJURY Month, Day, Year Hour a.m. 2PM p.m. 4/25/66		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/> Nursing Home		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Nursing Home		20f. (City or town) Cambridge	(County) Dor.	(State) Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE <i>John Mace Jr.</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED 5/21/66		
EXAMINER'S NAME (Type) John Mace Jr.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Address (Street, city, town, or county) Cambridge, Md.				
23a. BURIAL CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF May 24, 1966		23c. NAME OF CEMETERY OR CREMATORIUM Cold Spring Cemetery		23d. LOCATION (City, town or county) Cold Spring, New Jersey		(State)
24. FUNERAL DIRECTOR Hollingshead Funeral Home		ADDRESS Cape May, N.J.		25a. REC'D BY REGISTRAR Charles Judge		25b. REGISTRAR'S SIGNATURE Charles Judge		

20000
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FOR STATE
HEALTH DEPT.

TO FUNERAL DIRECTOR: This certificate should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 24 hours after death. If any detail is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any detail is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

06873

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06865

1. PLACE OF DEATH
a. COUNTY

DORCHESTER

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

RURAL CAMBRIDGE

c. LENGTH OF STAY IN lb

4 YRS.

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

EASTERN SHORE STATE HOSPITAL

3. NAME OF
DECEASED
(Type or print)

First

Middle

Last

DAISY MAE FARLOW

5. SEX

FEMALE

6. COLOR OR RACE

WHITE

7. MARRIED NEVER MARRIED

WIDOWED DIVORCED

8. DATE OF BIRTH

9/8/82

9. AGE (In years
last birthday)

83 yrs.

10. IF UNDER 1 YEAR

Months Days

11. IF UNDER 24 HRS.

Hours Min.

10a. RECENT OCCUPATION (Give kind of work
done during most of working life, even if retired)

TEACHER, POSTMISTRESS (Retired Cashier)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Md. Pittsville, Md.

12. CITIZEN OF WHAT COUNTRY

U.S.

13. FATHER'S NAME

BEN JAMIN DANIEL FARLOW, JR.

14. MOTHER'S MAIDEN NAME

LOUISIANA RYDER PARSONS

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give rank and dates of service)

NO

16. SOCIAL SECURITY NO.

213-16-7627

17. INFORMANT

Mrs. Harry (Ruth F.) Smith-Ocean City Blvd
Address
Salisbury, Maryland

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

TERMINAL PNEUMONIA

9047
Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause first.

DUE TO

(b)

DUE TO

(c)

FRACTURE NECK RIGHT FEMUR

INTERVAL BETWEEN
ONSET AND DEATH
4 DAYS

END POINT
19 DAYS

09
MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS
PRIMARY OR CONTRIBUTING
CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

UNKNOWN, FOUND IN BED WITH FRACTURED HIP.

20c. TIME OF INJURY Month, Day, Year
? Hour e.m.
p.m. 5/4/66, 19

20d. INJURY OCCURRED
While Not While
at work at work

20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)
CAMBRIDGE
(County)
DOR.
(State)
MD.

21. I certify that I took charge of the remains described above, held an Autopsy , Inspection , Inquiry , and in my opinion
death resulted from: Natural causes , Accident , Suicide , Homicide , Undetermined manner

ACTUAL
SIGNATURE

JOHN MACE JR.

CHIEF MEDICAL EXAMINER

M.D. ASSISTANT MEDICAL EXAMINER

DEPUTY MEDICAL EXAMINER

Address (Street, city, town, or county)

DATE SIGNED

5/23/66

22a. BURIAL, CREMATION,
REMOVAL (Specify)

Burial

22b. DATE THEREOF

May 25/1966

22c. NAME OF CEMETERY OR CREMATORI

Pittsville Cem. (Old Part)

22d. LOCATION (City, town, or county)

Pittsville, Maryland

(State)

23. FUNERAL DIRECTOR

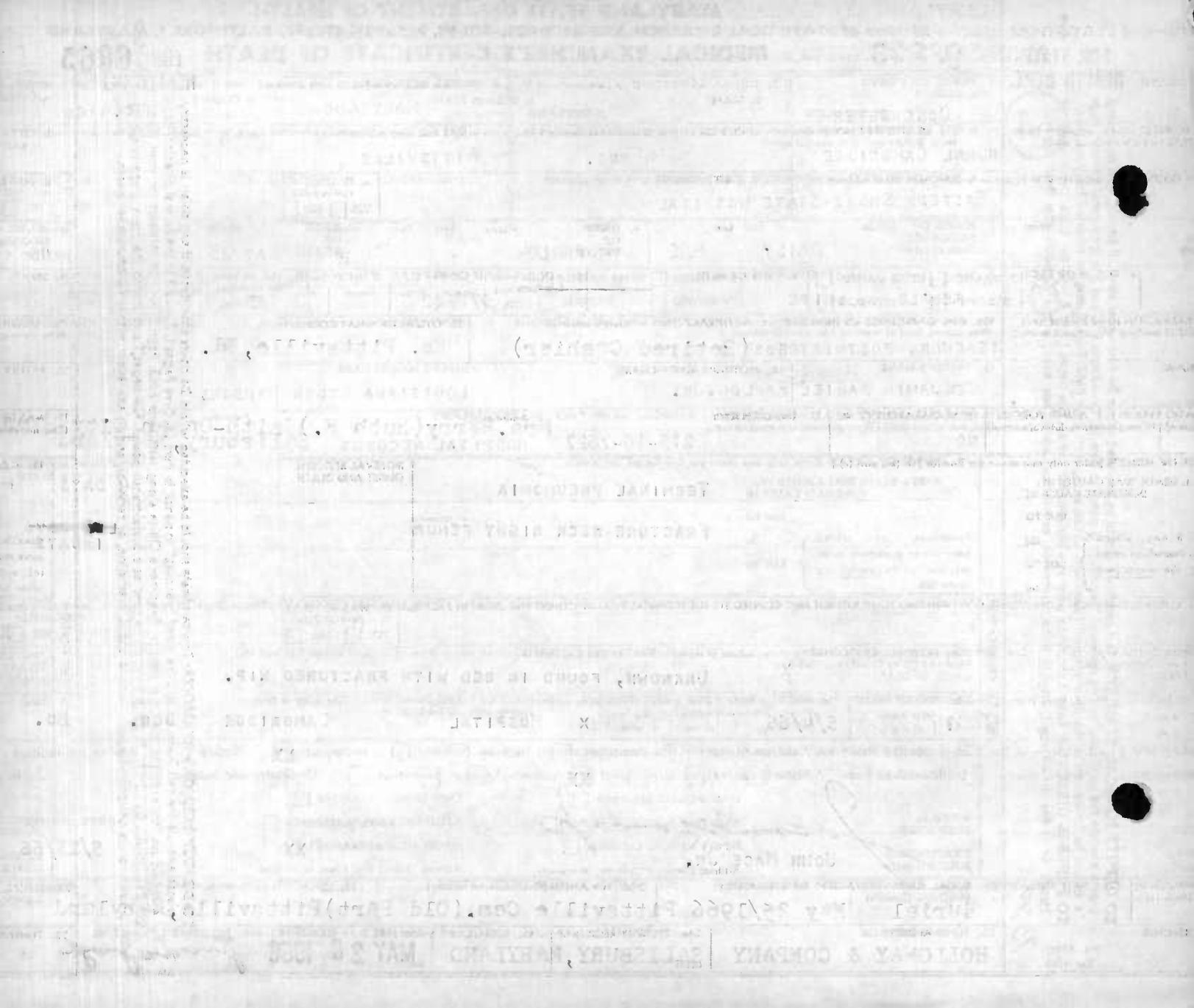
ADDRESS

HOLLOWAY & COMPANY SALISBURY, MARYLAND

24a. REC'D BY REGISTRAR

MAY 26 1966

24b. REGISTRAR'S SIGNATURE



HOTEL & COMPANY

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
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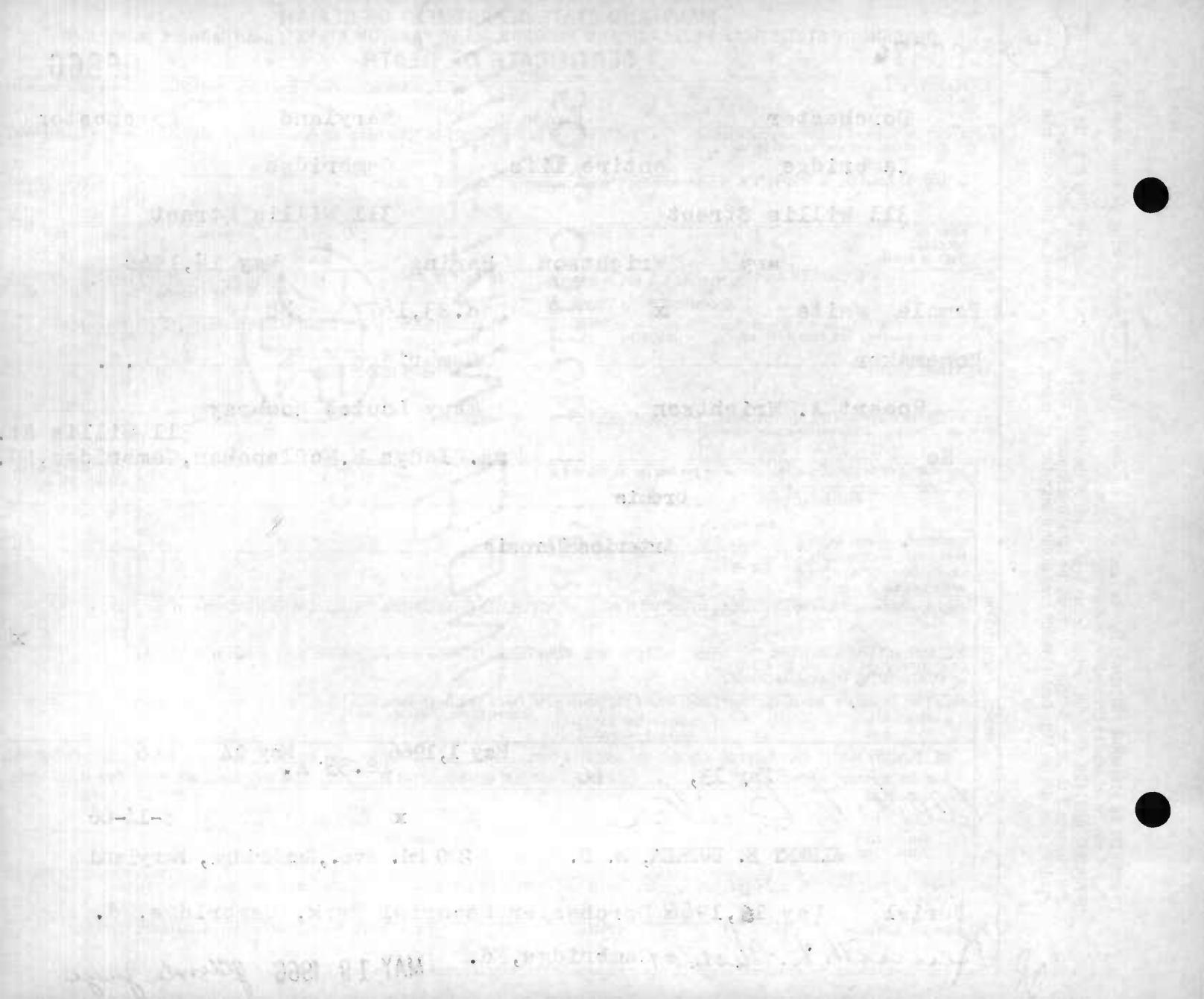
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

06874

06866

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Dorchester		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		b. COUNTY Dorchester	
c. LENGTH OF STAY IN 1b entire life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 311 Willis Street		d. STREET ADDRESS 311 Willis Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Mary Wrightson Haring		First	Middle
4. DATE OF DEATH May 14, 1966		Last	Month Day Year
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH Dec. 23, 1877		9. AGE (In years last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS 88 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Cambridge		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Robert A. Wrightson		14. MOTHER'S MADDEN NAME Mary Louise Mowbray	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 311 Willis St	
17. INFORMANT Mrs. Gladys H. McClenahan, Cambridge, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia			
4500 Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from May 1, 1966 to May 14, 1966 , that (I) (we) last saw the deceased alive on May 13, 1966 , and that death occurred at 22-35 A.M. from the causes and on the date stated above.		22b. DATE SIGNED 5-14-66	
22a. SIGNATURE Albert E. Bunker		22b. DATE SIGNED 5-14-66	
22c. PHYSICIAN'S NAME (Type) ALBERT E. BUNKER, M. D.		22d. ADDRESS 200 Md. Ave., Cambridge, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF May 14, 1966	
23c. NAME OF CEMETERY OR CREMATORIAL Dorchester Memorial Park, Cambridge, Md.		23d. LOCATION (City, town or county) (State)	
24. FUNERAL DIRECTOR Kenneth L. Shewey		ADDRESS Cambridge, Md.	
25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE J. Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

06875

CERTIFICATE OF DEATH

06867

1. PLACE OF DEATH a. COUNTY Dorchester		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland		b. COUNTY Dorchester					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN lb Two Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hurlock		d. STREET ADDRESS Thompson Street					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Cambridge Maryland Hospital						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)	First WILLIAM	Middle	Last HARVEY	4. DATE OF DEATH May 29 1966	Month Day Year	5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIOOWED <input type="checkbox"/> DIVORCEO <input type="checkbox"/>	8. DATE OF BIRTH May 10, 1910	9. AGE (In years last birthday) 56 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Self Employed		10b. KIND OF BUSINESS OR INDUSTRY Trucking		11. BIRTHPLACE (County & State, or foreign country) Dorchester Col, Md.		12. CITIZEN OF WHAT COUNTRY? USA					
13. FATHER'S NAME William Harvey		14. MOTHER'S MAIDEN NAME Eva Starr									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. -----		17. INFORMANT Mrs. Grace L. Harvey, Hurlock, Maryland		Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 260X		INTERCAPILLARY GLomerulosclerosis				INTERVAL BETWEEN ONSET AND DEATH 5 months					
Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. Diabetes mellitus		DUE TO (b) DUE TO (c)				15 years					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19											
21. I certify that (I) (this hospital) attended the deceased from January 13, 1966 , to May 29, 1966 , that (I) (we) last saw the deceased alive on May 29, 1966 , and that death occurred at 2:15 AM , from the causes and on the date stated above.		22a. SIGNATURE Carlos F Barroso		ATTENDING PHYS. <input checked="" type="checkbox"/>		ME. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) CARLOS F. BARROSO		22d. ADDRESS E.S.S. Hosp. Cambridge Md.									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF June 1, 1966		23c. NAME OF CEMETERY OR CREMATORIUM East New Market Cemetery		23d. LOCATION (City, town or county) East New Market, Maryland		(State)			
24. FUNERAL DIRECTOR LeCompte Funeral Service, Cambridge, Maryland		ADDRESS		25a. REC'D BY REGISTRAR JUN 2 1966		25b. REGISTRAR'S SIGNATURE Charles Judge					
VR A15 (4) 20M 1/65											

1 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, Then please remove carbon papers. Pages 1 and 2 director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND												CERTIFICATE OF DEATH		06868					
1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)				a. STATE				b. COUNTY							
Dorchester				MARYLAND				Md.				Dor							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				c. LENGTH OF STAY IN 1b				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				d. STREET ADDRESS							
Cambridge				4 days				East New Market				09-1							
NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)												e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
Cambridge Maryland																			
3. NAME OF DECEASED (Type or print)		First		Middle		Last		4. DATE OF DEATH		Month		Day		Year					
Carolyn						Hill		5		24		1966							
5. SEX		6. COLOR OR RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)		10. IF UNDER 1 YEAR		11. IF UNDER 24 HRS.							
Female		White		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9/30/1919		46 yrs.		Months		Days		Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country)				12. CITIZEN OF WHAT COUNTRY							
Housework								Penns				U.S.A.							
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME																	
Victor Winterberger		Mamie																	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16. SOCIAL SECURITY NO.				17. INFORMANT				Address							
No								Earl Hill, East New Market, Md.											
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).]												INTERVAL BETWEEN ONSET AND DEATH							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 5810 DUE TO Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ DUE TO												2 months							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 2022 Inactive Pulmonary Tuberculosis												19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.)															
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from 4/12/66, 19, to 5/24/66, that (I) (we) last saw the deceased alive on 7/24 1966, and that death occurred at 3:30 PM, from the causes and on the date stated above.												22b. DATE SIGNED 5/26/66							
22a. SIGNATURE Avenue Maryland												22b. DATE SIGNED 5/26/66							
22c. PHYSICIAN'S NAME (Type)				M.O. ATTENDING MED. DIRECTOR STAFF PHYS. <input type="checkbox"/> <input checked="" type="checkbox"/> <input type="checkbox"/>				22d. ADDRESS Lawrence Maryland MD Cambridge, Md											
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE THEREOF 5/27/66				23c. NAME OF CEMETERY OR CREMATORIAL East New Market				23d. LOCATION (City, town or county) East New Market, Md. (State)							
24. FUNERAL DIRECTOR				ADDRESS Burke Milloughby, East New Market, Md.				25a. REC'D BY REGISTRAR MAY 31 1966				25b. REGISTRAR'S SIGNATURE Charles Judge							

1 M

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

06877

CERTIFICATE OF DEATH

06869

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

PAGE 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Dorchester</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. STATE <i>Md</i>		b. COUNTY <i>Dor</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Cambridge</i>		c. LENGTH OF STAY IN 1b <i>5 days</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Vienna</i>		d. STREET ADDRESS <i>09-1</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Cambridge Maryland</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Alberta</i>		First <i>Elli</i>	Middle <i>s Hurley</i>	Last <i>5</i>	4. DATE OF DEATH Month <i>5</i> Day <i>27</i> Year <i>1966</i>		
5. SEX <i>Female</i>		6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>12/18/1886</i>	9. AGE (In years last birthday) <i>79 yrs.</i>	IF UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS <input type="checkbox"/> Months <i>0</i> Days <i>0</i> Hours <i>0</i> Min. <i>0</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housework</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <i>Maryland - Dor</i>		12. CITIZEN OF WHAT COUNTRY <i>U.S.A.</i>	
13. FATHER'S NAME <i>George Langfitt</i>		14. MOTHER'S MAIDEN NAME <i>Annie Delahoz</i>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Russell Hurley, Vienna, Md</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Occlusion</i>							
4201 Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) <i>Coronary Heart Disease</i> (c) <i>Hypertension</i>							
INTERVAL BETWEEN ONSET AND DEATH <i>2 weeks</i>							
2 yrs. 2 yrs.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) <i>Diabetes mellitus.</i>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>5/18/66</i> , 19 <i>66</i> , to <i>5/22</i> , 19 <i>66</i> , that (I) (we) last saw the deceased alive on <i>5/22</i> , 19 <i>66</i> , and that death occurred at <i>9:00 A.M.</i> from the causes and on the date stated above.							
22a. SIGNATURE <i>Lawrence Maryanov</i>		M.D. ATTENDING PHYS. <input type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <i>5/30/66</i>	
22c. PHYSICIAN'S NAME (Type) <i>Lawrence Maryanov</i>		22d. ADDRESS <i>610 Race St Cambridge, Md</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>5/30/66</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>Dor. Memorial</i>		23d. LOCATION (City, town or county) (State) <i>Cambridge Md</i>	
24. FUNERAL DIRECTOR <i>South J. McNaughton East New Market, Md.</i>		ADDRESS		25a. REC'D BY REGISTRAR DATE <i>JUN 1 1966</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

00212



1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18c. Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
MEDICAL EXAMINER'S CERTIFICATE OF DEATH													
C6878				06870									
1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rhodesdale - Rural				c. LENGTH OF STAY IN 1b 25 years									
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Near Reid's Grove				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) Levi (or Levy)				First	Middle	Last	4. DATE OF DEATH	Month	Day	Year			
						Jackson	May	20		1966			
5. SEX Male		6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 5, 1897	9. AGE (in years last birthday) 69 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days	Hours	Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Day Laborer				10b. KIND OF BUSINESS OR INDUSTRY Farm and Factory				11. BIRTHPLACE (State or foreign country) Virginia					
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes WW I				16. SOCIAL SECURITY NO. 218-20-6469				17. INFORMANT Viola Jackson, Rhodesdale, Md., RED Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) Coronary occlusion 4201 DUE TO Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)													
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.								20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE John Mace Jr. EXAMINER'S NAME (Type)				CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) Cambridge, Md.									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF May 24, 1966				23c. NAME OF CEMETERY OR CREMATORIUM Reid's Grove Cemetery					
24. FUNERAL DIRECTOR J. J. F. Farnham and Son, Federalsburg, Maryland				ADDRESS				25a. REC'D BY REGISTRAR MAY 25 1966 25b. REGISTRAR'S SIGNATURE Charles Judge					

resembling
benign
probabilistic

level - slabbed
array 12
future - slabbed
over a short time

as yet
constant
(used to) live
origin
intervening
reduced number
second year
meanful
meanful

000 e 5M slabbed, level, array 0040-05-812
no threshold measure

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

M

06879

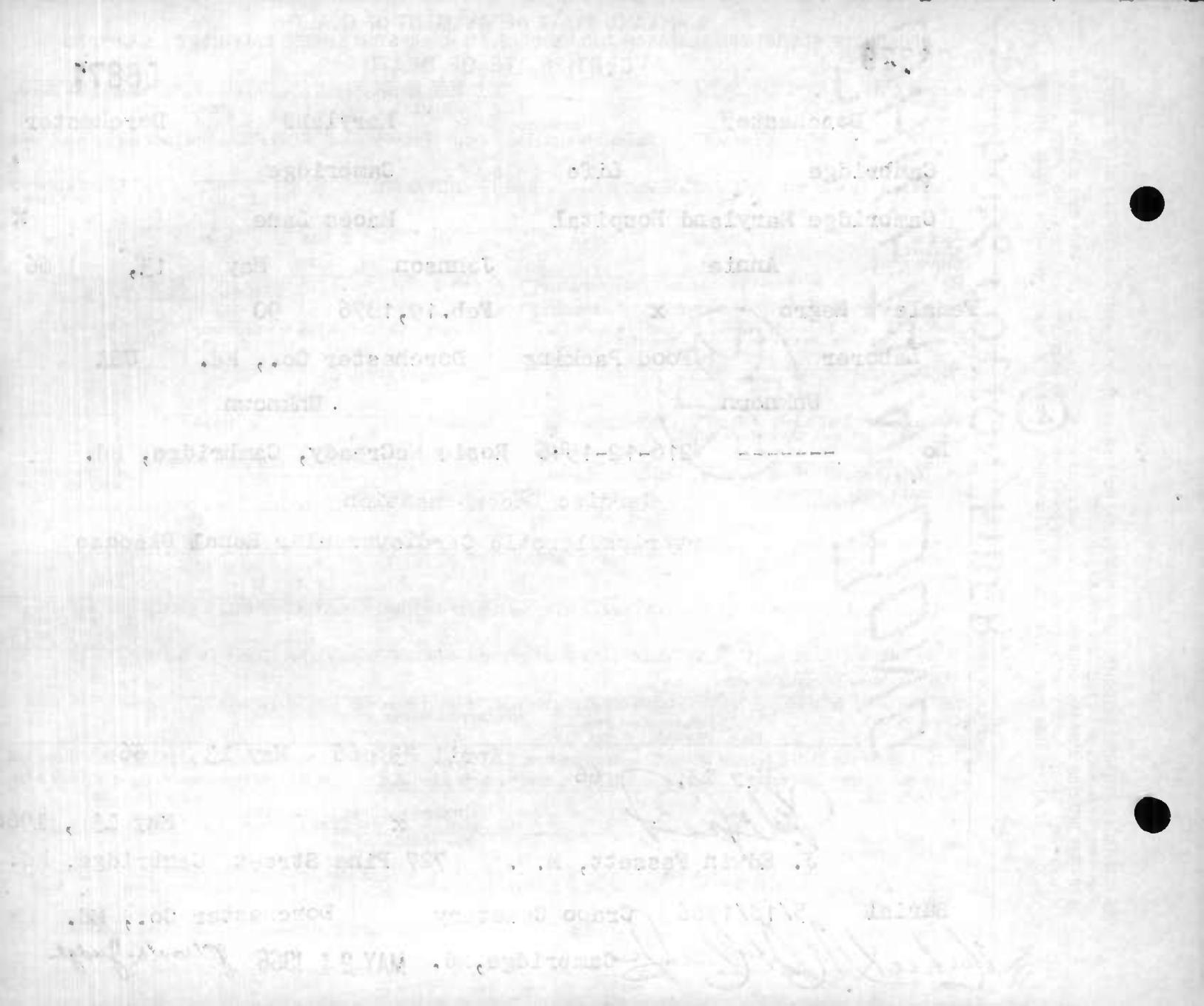
CERTIFICATE OF DEATH

06871

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Donchester		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cambridge		b. COUNTY Dorchester	
c. LENGTH OF STAY IN 1b Life		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cambridge	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Cambridge Maryland Hospital		d. STREET ADDRESS Maces Lane	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		e. DAY Year	
3. NAME OF DECEASED (Type or print) Annie		Last Johnson	Month Day Year May 13, 1966
4. DATE OF DEATH Feb. 19, 1876		5. SEX Female	6. COLOR OR RACE Negro
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 19, 1876	
9. AGE (in years last birthday) 90 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer	
10b. KIND OF BUSINESS OR INDUSTRY Food Packing		11. BIRTHPLACE (County & State, or foreign country) Dorchester Co., Md.	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Unknown	
14. MOTHER'S MAIDEN NAME Unknown		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No	
16. SOCIAL SECURITY NO. 216-12-1546		17. INFORMANT Rosie McCready, Cambridge, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 442X		INTERVAL BETWEEN ONSET AND DEATH Cardiac Decompensation	
Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. Arteriosclerotic Cardiovascular Renal Disease		DUE TO (b) DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from April 23, 1966 , to May 13, 1966 that (I) (we) last saw the deceased alive on May 19, 1966 , and that death occurred at M. from the causes and on the date stated above.			
22a. SIGNATURE <i>J. Edwin Fassett</i>		22b. DATE SIGNED May 13, 1966	
22c. PHYSICIAN'S NAME (Type) J. Edwin Fassett, M.D.		22d. ADDRESS 727 Pine Street Cambridge, Md.	23d. LOCATION (City, town or county) (State) Dorchester Co., Md.
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/18/1966	23c. NAME OF CEMETERY OR CREMATORIUM Crapo Cemetery
24. FUNERAL DIRECTOR <i>Charles W. Clark</i>		24b. ADDRESS Cambridge, Md.	25a. REC'D BY REGISTRAR DA MAY 24 1966
		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



M

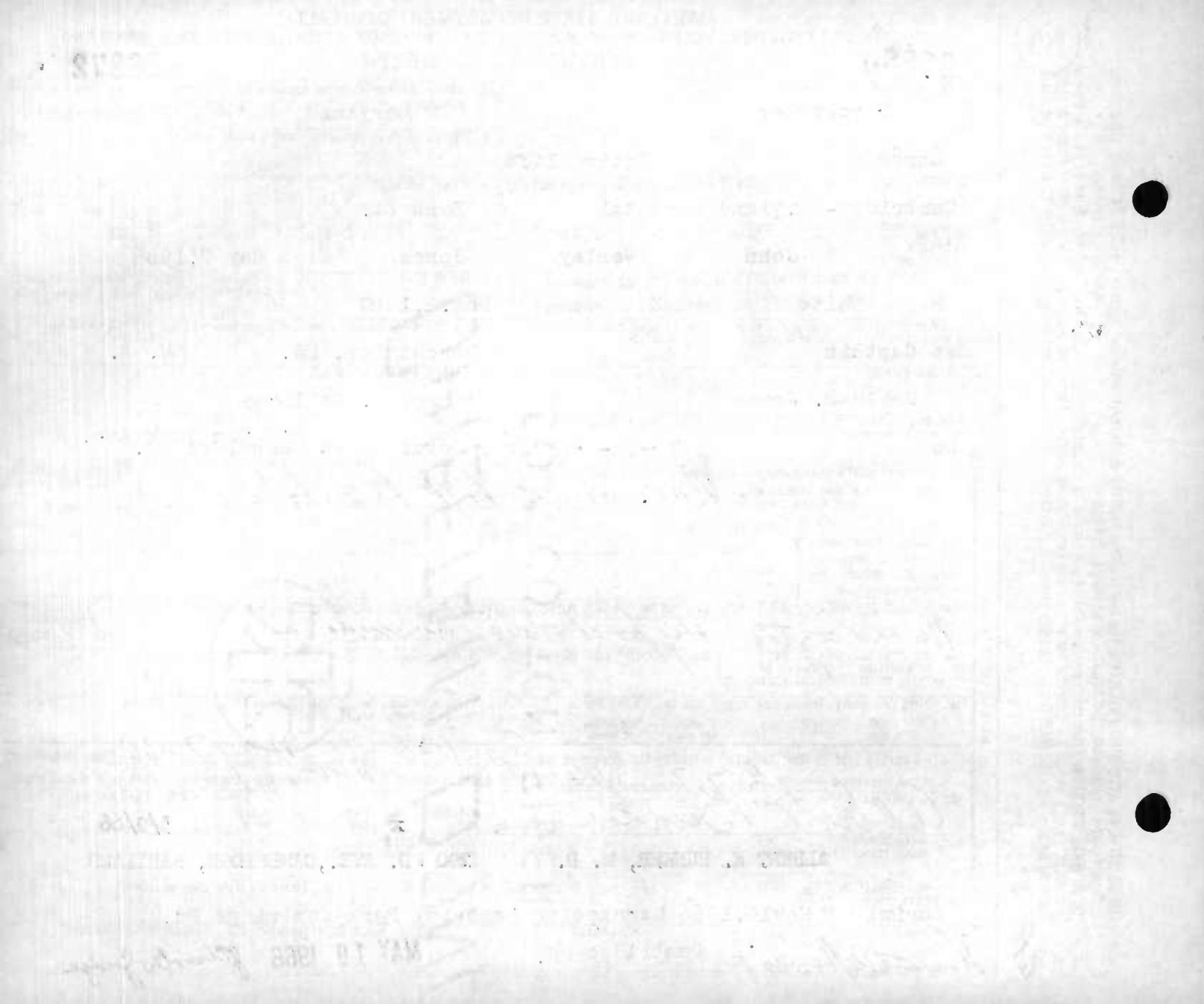
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please, remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) b. STATE Maryland b. COUNTY Dorchester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge c. LENGTH OF STAY IN 1b Entire life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 09-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Cambridge-Maryland Hospital		d. STREET ADDRESS Byrn St.	
3. NAME OF DECEASED (Type or print)	First John	Middle Wesley	Last Jones
4. DATE OF DEATH	Month May	Day 7, 1966	Year 19
5. SEX M	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Nov. 2, 1869
	WIOOWEO <input checked="" type="checkbox"/>	DIVORCED <input type="checkbox"/>	9. AGE (In years last birthday) 96 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sea Captain		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Dorchester, Md.		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME David B. Jones		14. MOTHER'S MAIDEN NAME Mary E. Calloway	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 213-34-4669 17. INFORMANT Address 210 Choptank Ave. Mrs. Novella Dean Cambridge Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pneumonia Left Lungs lobe.</i> DUE TO <i>490X</i> Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Microcytic Hypochromic anemia.</i>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>April 23, 1966</i> to <i>May 7, 1966</i> , that (I) (we) last saw the deceased alive on <i>May 7, 1966</i> , and that death occurred at <i>1115 M.</i> from the causes and on the date stated above.			
22a. SIGNATURE <i>Albert E. Bunker</i>		22b. DATE SIGNED <i>5/9/66</i>	
22c. PHYSICIAN'S NAME (Type) ALBERT E. BUNKER, M. D.		22d. ADDRESS 200 MD. AVE., CAMBRIDGE, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF May 10, 1966	
23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Dorchester Memorial Park Cambridge Md.		23d. LOCATION (City, town or county) (State)	
24. FUNERAL DIRECTOR Kenneth R. Horner Jr. Cambridge Md.		25a. REC'D BY REGISTRAR MAY 19 1966	
		25b. REGISTRAR'S SIGNATURE <i>J. Charles Judge</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

06873

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE	
Dorchester MARYLAND		Maryland Dorchester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b	
Cambridge		Life	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Cambridge Maryland Hospital		900 Phillips Street	
3. NAME OF DECEASED (Type or print)		First	Middle
Emory		Frances	Kane
4. DATE OF DEATH		Month	Day
5. SEX		5. COLOR OR RACE	6. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
Male		Negro	7. WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
Laborer		-----	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
David R. Kane		Mary Waters	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
Yes		W W II 217-10-8554	
17. INFORMANT		Address	
Margaret Stafford		Cambridge, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Malignant Hypertension			
445X Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) _____ (c) _____		DUE TO	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERRLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Uremia	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
19			
21. I certify that (I) (this hospital) attended the deceased from April 11, 1966 to May 22, 1966 , that (I) (we) last saw the deceased alive on May 22, 1966 , and that death occurred at M , from the causes and on the date stated above.		22b. DATE SIGNED 5-22-66	
22a. SIGNATURE <i>J. Edwin Fassett</i>		22b. DATE SIGNED 5-22-66	
22c. PHYSICIAN'S NAME (Type) J. Edwin Fassett, M.D.		22d. ADDRESS 827 Pine Street Cambridge, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/28/66	23c. NAME OF CEMETERY OR CREMATORIUM Madison
24. FUNERAL DIRECTOR <i>Judith C. Dylan</i>		23d. LOCATION (City, town or county) (State) Dorchester Co., Md.	
		25a. REC'D BY REGISTRAR MAY 25 1968	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>
		DATE	

STOP

BY 1900 hrs - 24 APR 1968

6

RECORDED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06874

1. PLACE OF DEATH a. COUNTY <i>Dorchester</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Talbot</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Cambridge</i>		c. LENGTH OF STAY IN 1b <i>15 yr 3 mo 14 d.</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Eastern Shore State Hosp.</i>		d. STREET ADDRESS <i>Wittman</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Walter</i>		First <i>—</i>	Middle <i>—</i>
4. DATE OF DEATH Month <i>May</i>		Last <i>Keys</i>	Year <i>21 1966</i>
S. SEX <i>m</i>	6. COLOR OR RACE <i>w</i>	7. MARRIED NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <i>6-21-93</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Painter</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>—</i>	11. BIRTHPLACE (County & State, or foreign country) <i>Maryland</i>
13. FATHER'S NAME <i>Samuel Keys</i>		14. MOTHER'S MAIDEN NAME <i>Sarah Proctor</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>213-22-9504</i>	17. INFORMANT Address <i>Eastern Shore State Hosp.</i>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>491X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) stating the underlying cause (c)		Bronchopneumonia, bilateral	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <i>01-01-67</i> to <i>05-21-66</i> that (I) (we) last saw the deceased alive on <i>19</i> , and that death occurred at <i>5-21-66</i> M, from causes and on the date stated above		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
22a. SIGNATURE <i>Robert Breckin</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <i>5-21-66</i>
22c. PHYSICIAN'S NAME (Type) <i>Peter W. Rieckart</i>		22d. ADDRESS <i>5 - New Market Rd</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>5-24-66</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Albion Cemetery</i>
24. FUNERAL DIRECTOR <i>V. Hamilton Harrison, Jr. Wilcox</i>		ADDRESS	25a. RECORD BY REGISTRATION DATE <i>MAY 24 1966</i>
			25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>

47330

STAGE 30 - STANDBY

3000



To HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06883

CERTIFICATE OF DEATH

06875

1. PLACE OF DEATH a. COUNTY <i>Dorchester</i>	MARYLAND	2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i>	b. COUNTY <i>Worcester</i>
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Campobello (Rural)</i>	c. LENGTH OF STAY IN 1b <i>5 years</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Berlin</i>	d. STREET ADDRESS <i>222</i>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Eastern Shore State Hosp-</i>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		

3. NAME OF DECEASED (Type or print) <i>Nora Fletcher Knox</i>	First	Middle	Lost	4. DATE OF DEATH Month <i>May</i>	Doy <i>29</i>	Year <i>1966</i>			
5. SEX <i>F</i>	6. COLOR OR RACE <i>wh</i>	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>10-28-80</i>	9. AGE (In years last birthday) <i>80</i>	IF UNDER 1 YEAR Months <i>0</i>	IF UNDER 24 HRS. Days <i>0</i>	Hours <i>0</i>	Min. <i>0</i>

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>SELFEMP</i>	11. BIRTHPLACE (County & State or foreign country) <i>Virginia</i>	12. CITIZEN OF WHAT COUNTRY? <i>USA</i>
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13. FATHER'S NAME <i>David Henry Fletcher</i>	14. MOTHER'S MAIDEN NAME <i>Barssia Bell</i>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/> (If yes give war or date of service) <i>490X</i>	16. SOCIAL SECURITY NO. <i>212-16-1078</i>	17. INFORMANT <i>Records - Hospital</i>	Address <i>301 W. Preston Street</i>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Septicemic Shock</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <i>Labor Pneumonia</i> stating the underlying cause (c) DUE TO 3 days	INTERVAL BETWEEN DEATH AND DEATH <i>3 days</i>
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Diabetes Mellitus</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
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20a. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>While at work</i>	20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>5-12, 1961</i>	20f. (City or town) (County) (State) <i>5-28, 1966</i>
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21. I certify that # (this hospital) attended the deceased from <i>5-12, 1961</i> to <i>5-28, 1966</i> , that (I) (we) last saw the deceased alive on <i>5-28, 1966</i> , and that death occurred at <i>129 W. Preston Street</i> , from causes and on the date stated above.

22. SIGNATURE <i>James F Smith</i>	M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 22b. DATE SIGNED <i>5-28-66</i>
22c. PHYSICIAN'S NAME (Type) <i>James F Smith M.D.</i>	22d. ADDRESS <i>Riverside</i>

23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE THEREOF <i>6/1/66</i>	23c. NAME OF CEMETERY OR CREMATORIUM <i>RIVERSIDE</i>	23d. LOCATION (City or Town) (County) (State) <i>BERLIN WOR. MD</i>
24. FUNERAL DIRECTOR <i>Anna A. Burbage Berlin Md.</i>	ADDRESS <i>1000 W. Preston Street</i>	25a. REC'D BY REGISTRAR <i>JUN 1 1966</i>	25b. REGISTRAR'S SIGNATURE <i>Charles J. ...</i>

2290

100

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

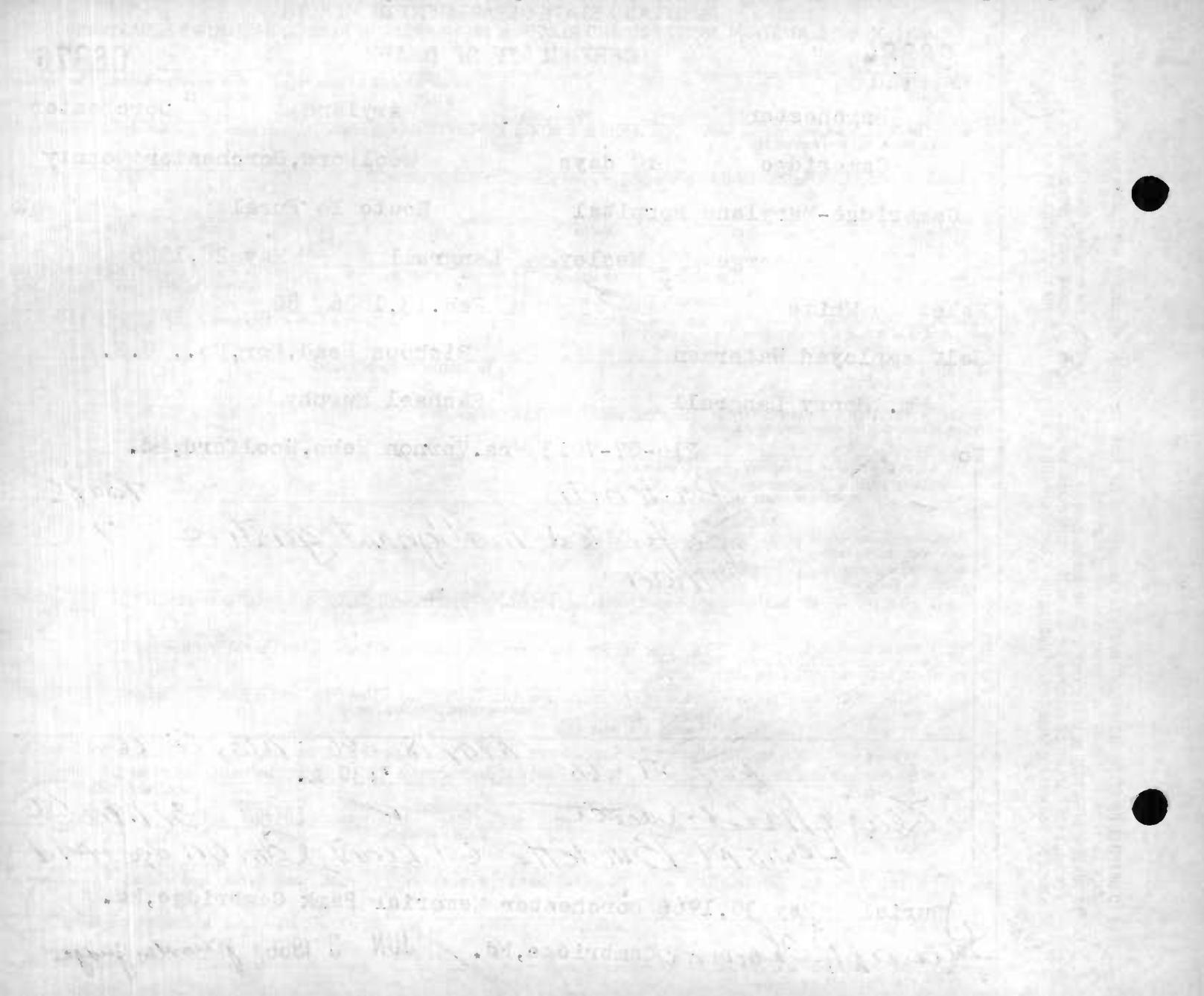
CERTIFICATE OF DEATH

06876

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal of any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE	
Dorchester MARYLAND		Maryland Dorchester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b	
Cambridge		10 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		Woolford, Dorchester County	
Cambridge-Maryland Hospital		d. STREET ADDRESS	
		Route 16 Rural	
e. IS RESIDENCE ON A FARM?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First	Middle
		George	Wesley
4. DATE OF DEATH		Month	Day Year
May 28, 1966		19	
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
Male		White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
Self employed Waterman		Bishops Head, Dor. Co., U.S.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
Wm. Henry Langrall		Rachael Murphy	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
No		17. INFORMANT	
		Address	
214-07-7013		Mrs. Vernon Webb, Woolford, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pentonitis</i>			
151X Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last.			
DUE TO (b) <i>Perforated malignant gastric ulcer</i> ?			
DUE TO (c) <i>Ulcer</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>May 18, 1966</i> , to <i>May 18, 1966</i> that (I) (we) last saw the deceased alive on <i>May 27, 1966</i> , and that death occurred at <i>3:30 PM</i> from the causes and on the date stated above.			
22a. SIGNATURE		22b. DATE SIGNED	
<i>Lewis M. Burdette</i>		31 May 66	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
Lewis M. Burdette		601 Locust, Cambridge, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF	
Burial		May 30, 1966	
23c. NAME OF CEMETERY OR CREMATORIUM		23d. LOCATION (City, town or county) (State)	
Dorchester Memorial Park		Cambridge, Md.	
24. FUNERAL DIRECTOR		ADDRESS	
<i>James R. Thomas</i>		Cambridge, Md.	
25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
JUN 3 1966		<i>J Charles Judge</i>	



1 M

FOR STATE
HEALTH DEPT.

To DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with your files.

To FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06885

06877

1. PLACE OF DEATH a. COUNTY <i>Dorchester</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Worcester</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural Cambridge Ages. smo.</i>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Snow Hill, Md. (rural)</i>		d. STREET ADDRESS <i>23-2</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Eastern Shore State Hospital</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <i>Louis</i>	Middle <i>Christ</i>	Last <i>Johnson</i>	4. DATE OF DEATH <i>5-12 1966</i>	Month <i>5</i>	Day <i>12</i>	Year <i>1966</i>
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>4-10-1947</i>	9. AGE (in years last birthday) <i>40 yrs.</i>	IF UNDER 1 YEAR Months <i>4</i>	IF UNDER 24 HRS. Days <i>7</i>	Hours <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Clerk</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Store</i>		11. BIRTHPLACE (State or foreign country) <i>North Carolina</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Andrew Johnson</i>		14. MOTHER'S MAIDEN NAME <i>Nettie Rasmussen</i>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Hospital Record</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) <i>PNEUMONIA</i>							
493X DUE TO Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause first. (b) _____ DUE TO (c) _____							
INTERVAL BETWEEN ONSET AND DEATH <i>2 days</i>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <i>19</i>		20f. (City or town) (County) (State)					
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <i>John Mace Jr.</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED <i>5/12/66</i>	
EXAMINER'S NAME (Type) <i>JOHN MACE JR.</i>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		Address (Street, city, town, or county) <i>Snow Hill, Md.</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>5/12/66</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>McKinney Pres. Com.</i>		23d. LOCATION (City, town or county) (State) <i>Snow Hill, Md.</i>	
24. FUNERAL DIRECTOR <i>Kenneth Shewell Jr.</i>		ADDRESS <i>Dennis Funeral Home Snow Hill, Md.</i>		25a. REC'D BY REGISTRAR <i>MAY 16 1966</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

Minneapolis

John Wayne Gacy

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND												06878	
CERTIFICATE OF DEATH													
1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Caroline									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hurlock				c. LENGTH OF STAY IN 1b 1 mon. 4 days				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Federalsburg 05-2					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Belle Haven Nursing Home 90				d. STREET ADDRESS Greenridge Road				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)		First Edward	Middle Everett	Last Linekin	4. DATE OF DEATH Month May 11 Day Year 19 66								
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 8, 1885	9. AGE (In years last birthday) 80 yrs.	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Stationary Engineer - College		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Booth Bay Harbor, Maine		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Everett E. Linekin				14. MOTHER'S MAIDEN NAME Mary Swett									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 100-01-9922		17. INFORMANT Elizabeth A. Linekin, Federalsburg, Md.		Address							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic carcinomatosis												INTERVAL BETWEEN ONSET AND DEATH 0 mmos	
1538 Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) Colonic Malignancy with spread to the liver (c) 6 mos													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) Secondary Anemia and malnutrition due to the above												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) While at work									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from 3/29/66 , 19 66 , to 5/11/66 , 19 66 , that (I) (we) last saw the deceased alive on 5/11/66 , 19 66 , and that death occurred at 10:40 , from the causes and on the date stated above.												22b. DATE SIGNED May 13, 1966	
22a. SIGNATURE H. B. Plummer				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22c. PHYSICIAN'S NAME (Type) Harold B. Plummer, M.D.								22d. ADDRESS Preston, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF May 14, 1966		23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Hill Crest Cemetery		23d. LOCATION (City, town or county) Federalsburg, Maryland				(State)	
24. FUNERAL DIRECTOR J. J. Farnham and Son, Federalsburg, Maryland				25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE MAY 23 1966 Charles Judge								DATE	

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06887

CERTIFICATE OF DEATH

06879

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or attending physician. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge	c. LENGTH OF STAY IN lb 3 months	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Eastern Shore State Hospital		d. STREET ADDRESS Pleasant St.	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) Edith	First Edith	Middle 	Last MEVEDITH
4. DATE OF DEATH 5-22-66	Month 5	Doy 22	Year 1966
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-16-04
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY -	11. BIRTHPLACE (County & State, or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? A.S.A.
13. FATHER'S NAME SEWELL Wooten	14. MOTHER'S MAIDEN NAME Effie Moore		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. -	17. INFORMANT	Address
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PNEUMONIA			
DUE TO (b) CEREBRAL VASCULAR ACCIDENT			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) ARTERIOSCLEROSIS + DIABETES			
DUE TO			
INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
CHRONIC BRAIN SYNDROME			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 2-38 , 19 66 , to 5-22 , 19 66 that (I) (we) last saw the deceased alive on 5-22 19 66 , and that death occurred at AM , from causes and on the date stated above.			
22a. SIGNATURE Felipe M. Dominguez	M.D. <input type="checkbox"/> ATTENDING PHYS. FELIPE M. DOMINGUEZ, M.D.	MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	22b. DATE SIGNED 5-22-66
22c. PHYSICIAN'S NAME (Type) FELIPE M. DOMINGUEZ, M.D.	22d. ADDRESS F.S.S.H.		

23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 5/24/66	23c. NAME OF CEMETERY OR CREMATORIAL Greenlawn Cemetery	23d. LOCATION (City or Town) (County) (State) Cambridge Dor. Md
24. FUNERAL DIRECTOR Honest R. House for Cambridge M.D.	ADDRESS	25a. REC'D BY REGISTRAR MAY 31 1966	25b. REGISTRAR'S SIGNATURE Charles Judge

6100

NOV 29 1967 GPO

18600

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06888

CERTIFICATE OF DEATH

06880

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal.

1. PLACE OF DEATH o. COUNTY <i>Dorchester</i>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Combeide (Rural)</i>		c. LENGTH OF STAY IN lb <i>1 month</i>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Chester</i>		d. STREET ADDRESS <i>Marling Farms.</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Eastern Shore State Hospital</i>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Stetson</i>		First <i>BENJAMIN</i>	Middle <i>RIDGETT</i>
4. DATE OF DEATH Month <i>MAY</i>		Month <i>29</i>	Doy Year <i>19 66</i>
S. SEX <i>M</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED DIVORCED <input checked="" type="checkbox"/>
8. DATE OF BIRTH <i>3-13-1899</i>	9. AGE (In years last birthday) <i>67 yrs.</i>	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS. DAYS <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Merchant Seaman</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <i>Queen Anne Co. Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Arthur Ridgett</i>		14. MOTHER'S MAIDEN NAME <i>Nettie Barnette</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>Unknown</i>		16. SOCIAL SECURITY NO. <i>24-16-6056</i>	
17. INFORMANT <i>Records Hospital</i>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Gastrintestinal Hemorrhage</i>		INTERVAL BETWEEN ONSET AND DEATH <i>48 hr.</i>	
DUE TO <i>578x</i>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>chronic Pulmonary Emphysema; Myocarditis</i>			
19. WAS AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>4-30, 1966, to 5-28, 1966</i>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Stevensville Md.</i>
20f. (City or town) <i>Stevensville</i>		(County) <i>Md.</i>	(State) <i>Md.</i>
21. I certify that <input type="checkbox"/> (this hospital) attended the deceased from <i>4-30, 1966, to 5-28, 1966</i> , that (I) <input type="checkbox"/> (we) last saw the deceased alive on <i>5-29, 1966</i> , and that death occurred at <i>12 PM</i> , from causes and on the date stated above.			
22a. SIGNATURE <i>James F Smith</i>		M.D. <input type="checkbox"/> ATTENDING PHYS. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <i>5-29-66</i>
22c. PHYSICIAN'S NAME (Type) <i>James F Smith MD</i>		22d. ADDRESS <i>Eastern Shore State Hospital</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>July 1, 1966</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Stevensville Md.</i>
24. FUNERAL DIRECTOR <i>Edgar L. Lane Church Hill Md.</i>		ADDRESS	25a. REC'D BY REGISTRAR DATE <i>JUN 1 1966</i>
			25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>

60100

MEASURES

8920

REPORT

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

1 To HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

10 To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or attending physician. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

06889

CERTIFICATE OF DEATH

1 PLACE OF DEATH a. COUNTY <i>Dorchester</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Wicomico</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Cambridge</i>		c. LENGTH OF STAY IN lb <i>4 yr 6 mo 14 d</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Salisbury</i>		22 2	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Eastern Shore State Hosp.</i>		d. STREET ADDRESS <i>Mt. Herman Road</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		5 22 1966	
3. NAME OF DECEASED (Type or print) <i>Edna</i>		First	Middle	Last	4. DATE OF DEATH <i>Hills</i>	Month	Day Year
S. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <i>06-11-90</i>	9. AGE (In years last birthday) <i>75 yrs.</i>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Attendant</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY <i>USA</i>	
13. FATHER'S NAME <i>Daniel Moore</i>		14. MOTHER'S MAIDEN NAME <i>Nancy Wilson</i>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>unk</i>		16. SOCIAL SECURITY NO. <i>unk</i>		17. INFORMANT <i>Eastern Shore State Hosp.</i>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>465X</i>		DUE TO <i>Pneumonia due to polio, Ril.</i>				INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <i>(County)</i> <i>(State)</i>	
21. I certify that (I) (this hospital) attended the deceased from <i>11-22-66</i> to <i>May 22 1966</i> , that (I) (we) last saw the deceased alive on <i>May 22 1966</i> , and that death occurred at <i>1 PM</i> , from causes and on the date stated above.							
22a. SIGNATURE <i>J. W. Kieckert</i>		M.D. <input type="checkbox"/> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <i>5-33-66</i>			
22c. PHYSICIAN'S NAME (Type) <i>P. W. Rieckert</i>		22d. ADDRESS <i>R - New Market, Md</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>May 24, 1966</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>Greenlawn Cemetery</i>		23d. LOCATION (City or Town) <i>(County)</i> <i>(State)</i> <i>Cambridge, Maryland</i>	
24. FUNERAL DIRECTOR <i>LeCompte Funeral Service, Cambridge, Maryland</i>		ADDRESS		25a. REC'D. BY REGISTRAR <i>MAY 24 1966</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	
VR A15 (4) 20 M 1/66				DATE			

• 9

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND												CERTIFICATE OF DEATH		06882	
1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester											
b. CITY OR TDWN (If outside corporate limits, write RURAL and give nearest town) Cambridge				c. LENGTH OF STAY IN 1B Life				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge							
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Cambridge Maryland Hospital								d. STREET ADDRESS 317 Belvedere Avenue							
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
3. NAME OF DECEASED (Type or print) First JOSEPH Middle L. Last MILLS				4. DATE OF DEATH May 19, 1966											
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 17, 1913		9. AGE (In years last birthday) 52 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Grain Dept. Mgr.				10b. KIND OF BUSINESS OR INDUSTRY Grain Factory				11. BIRTHPLACE (County & State, or foreign country) Cambridge, Maryland				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Walter P. Mills				14. MOTHER'S MAIDEN NAME Lena Horseman											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes WW II				16. SOCIAL SECURITY NO. 217-10-8039				17. INFORMANT Mrs. Joseph L. Mills, Cambridge, Maryland				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 180X <i>Hepnephrosis of liver</i> DUE TO Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>deffen Melastom</i> DUE TO (c)												INTERVAL BETWEEN ONSET AND DEATH 1 yr			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <i>Apr 1, 1966</i> , to <i>May 19, 1966</i> , that (I) (we) last saw the deceased alive on <i>May 19, 1966</i> , and that death occurred at <i>IP</i> M, from the causes and on the date stated above.															
22a. SIGNATURE <i>James U. Thompson</i>				22b. DATE SIGNED 5/20/66											
22c. PHYSICIAN'S NAME (Type) James U. Thompson, MD				22d. ADDRESS Locust Street, Cambridge, Maryland											
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF May 22, 1966		23c. NAME OF CEMETERY OR CREMATORIUM Dorchester Memorial Park		23d. LOCATION (City, town or county) (State) Cambridge, Maryland							
24. FUNERAL DIRECTOR LeCompte Funeral Service, Cambridge, Maryland				ADDRESS											
				25a. REC'D BY REGISTRAR MAY 23 1966				25b. REGISTRAR'S SIGNATURE <i>J Charles Judge</i>							
VR A15 (4) 20M 1/65															

3883

polynomial

analytic

refinement

polynomial

analytic

old

old

general iterative TC

fastest possible algorithm?

old

old

old

old, II, III

old

analytic, cubic, general iterative, old, old

numerical trial

old, II, III

analytic, cubic, old, old, old, old, old, old

analytic

analytic, cubic, old, old

analytic, cubic, fast, fastest, iteration, old, old, old

analytic, cubic, fast, fastest, iteration, old, old



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

66891

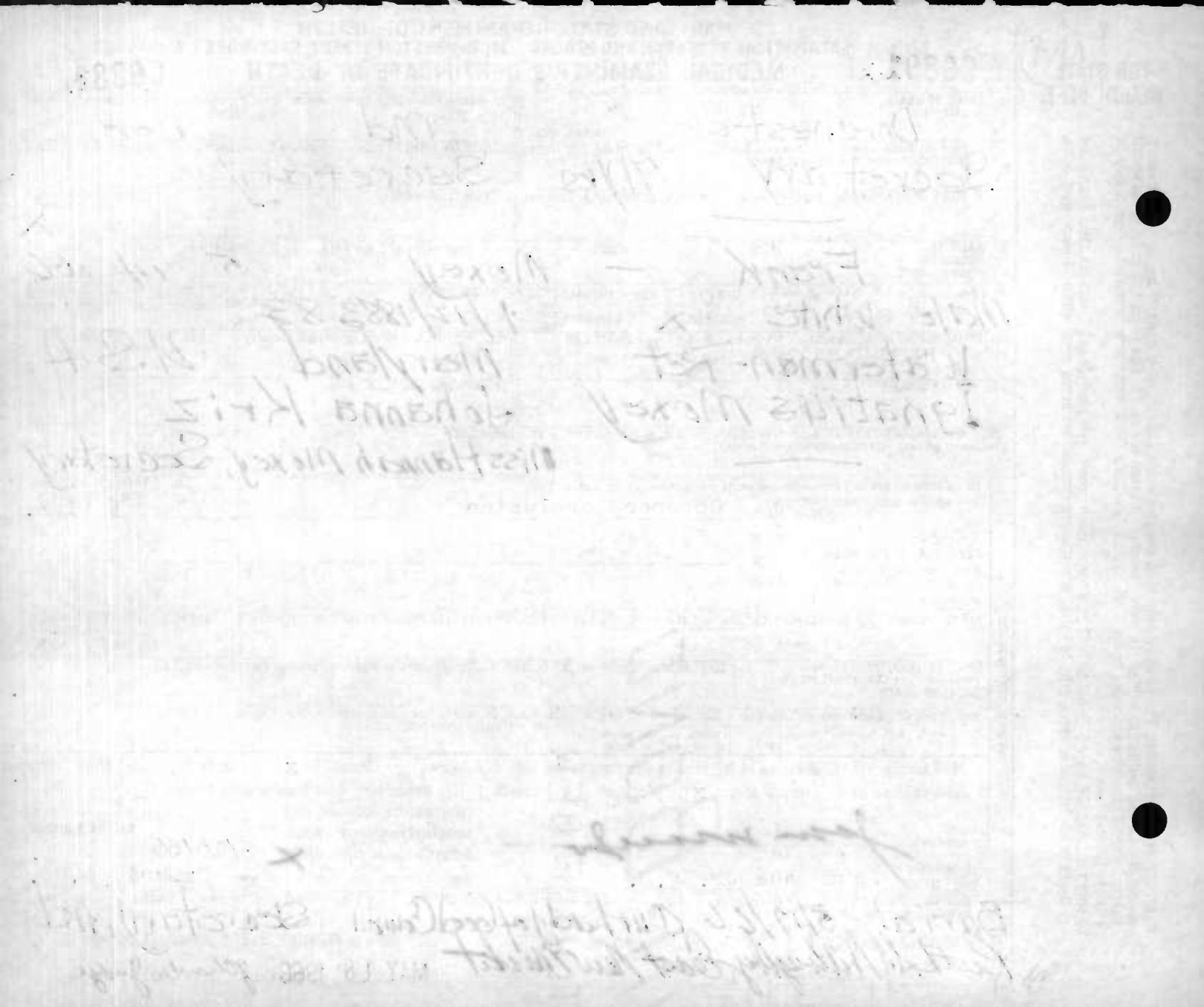
06883

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Dorchester</i>		2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>Dor.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Secretary</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Secretary</i>	
c. LENGTH OF STAY IN 1b <i>71 yrs</i>		d. STREET ADDRESS <i>09-1</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Frank</i>	First <i>M</i>	Middle <i>-</i>	Last <i>Moxey</i>
4. DATE OF DEATH <i>5 14 1966</i>	Month	Day	Year
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>1/12/1883</i>
9. AGE (In years last birthday) <i>83</i>	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Waterman - Ret</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>INDUSTRY</i>	11. BIRTHPLACE (State or foreign country) <i>Maryland</i>
12. CITIZEN OF WHAT COUNTRY <i>A.S.A.</i>	13. MOTHER'S NAME <i>Ignatius Moxey</i>		
14. MOTHER'S MAIDEN NAME <i>Sophanna Kriz</i>	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>None</i>		
16. SOCIAL SECURITY NO. <i>123-45-6789</i>	17. INFORMANT <i>Miss Hannah Moxey, Secretary</i>	Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary occlusion</i>			INTERVAL BETWEEN ONSET AND DEATH <i>5 Mins.</i>
4201 Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)			DUE TO
DUE TO			(b)
DUE TO			(c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <i>19</i> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>factory</i>
20f. (City or town) <i>Cambridge</i>		(County) <i>Md.</i>	(State) <i>Md.</i>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>John Mace Jr. M.D.</i>			
EXAMINER'S NAME (Type) <i>John Mace Jr. M.D.</i>			
22. DATE SIGNED <i>5/16/66</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
Address (Street, city, town, or county) <i>Cambridge, Md.</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>5/17/66</i>	
23c. NAME OF CEMETERY OR CREMATORIUM <i>Cemetery of Good Council</i>		23d. LOCATION (City, town or county) <i>Secretary, Md.</i>	
24. FUNERAL DIRECTOR <i>Ruth J. Philiberry, East New Market</i>		25a. ADDRESS <i>APPROVED</i>	
25b. REGISTRAR'S SIGNATURE		25c. REC'D BY REGISTRAR <i>May 18 1966</i>	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

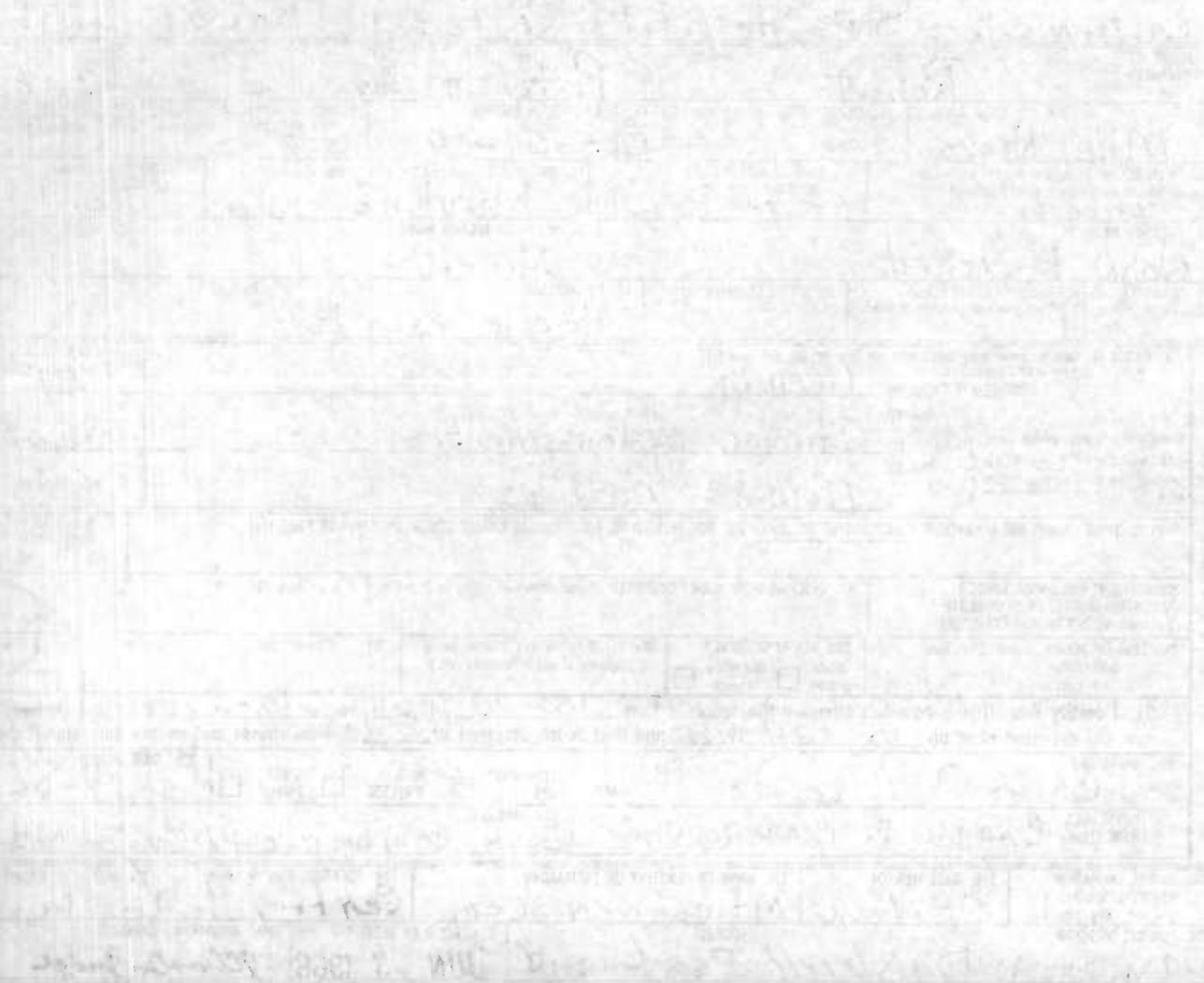
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CERTIFICATE OF DEATH						06884	
1. PLACE OF DEATH o. COUNTY Dorchester MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland b. COUNTY Queen Anne			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN lb 19 months		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Church Hill		17-3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Eastern Shore State Hospital				d. STREET ADDRESS Route #1 Box 61		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Robert Middle Lost Pritchett		4. DATE OF DEATH Month 5 Doy 27 Year 1966					
5. SEX Male Negro		6. COLOR OR RACE 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5-09-09		9. AGE (In years lost birthday) 57 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY STATE ROAD		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Pritchett		14. MOTHER'S MAIDEN NAME Minnie					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Hospital Records		Address	
IB. CAUSE OF DEATH (Enter only one cause per line for (o), (b), and (c).)							
PART I. DEATH WAS CAUSED BY:							
IMMEDIATE CAUSE (o) Uremia DUE TO 260X							
Conditions, if any, which gave rise to immediate cause (o), stating the underlying cause (b) Chronic pyelonephritis DUE TO 6 months							
stating the underlying cause (c) Diabetes mellitus DUE TO years							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 10-30, 1964, to 5-27, 1966 that (I) (we) last saw the deceased alive on 5-27, 1966, and that death occurred at 7A.M. from causes and on the date stated above.							
22a. SIGNATURE Carlos F. BARROS		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 5-27-66			
22c. PHYSICIAN'S NAME (Type) CARLOS F. BARROS		22d. ADDRESS ESSH. Cambridge Dorchester Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5-31-66		23c. NAME OF CEMETERY OR CREMATORIAL M+vernon cem		23d. LOCATION (City or Town) (County) (State) Catfreville 2A. Md.	
24. FUNERAL DIRECTOR James R Dashell Esq for me		ADDRESS		25a. REC'D BY REGISTRAR JUN 3 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	
VR A15 (4) 20 M 1/66							

2300

11450 TO 114900Z

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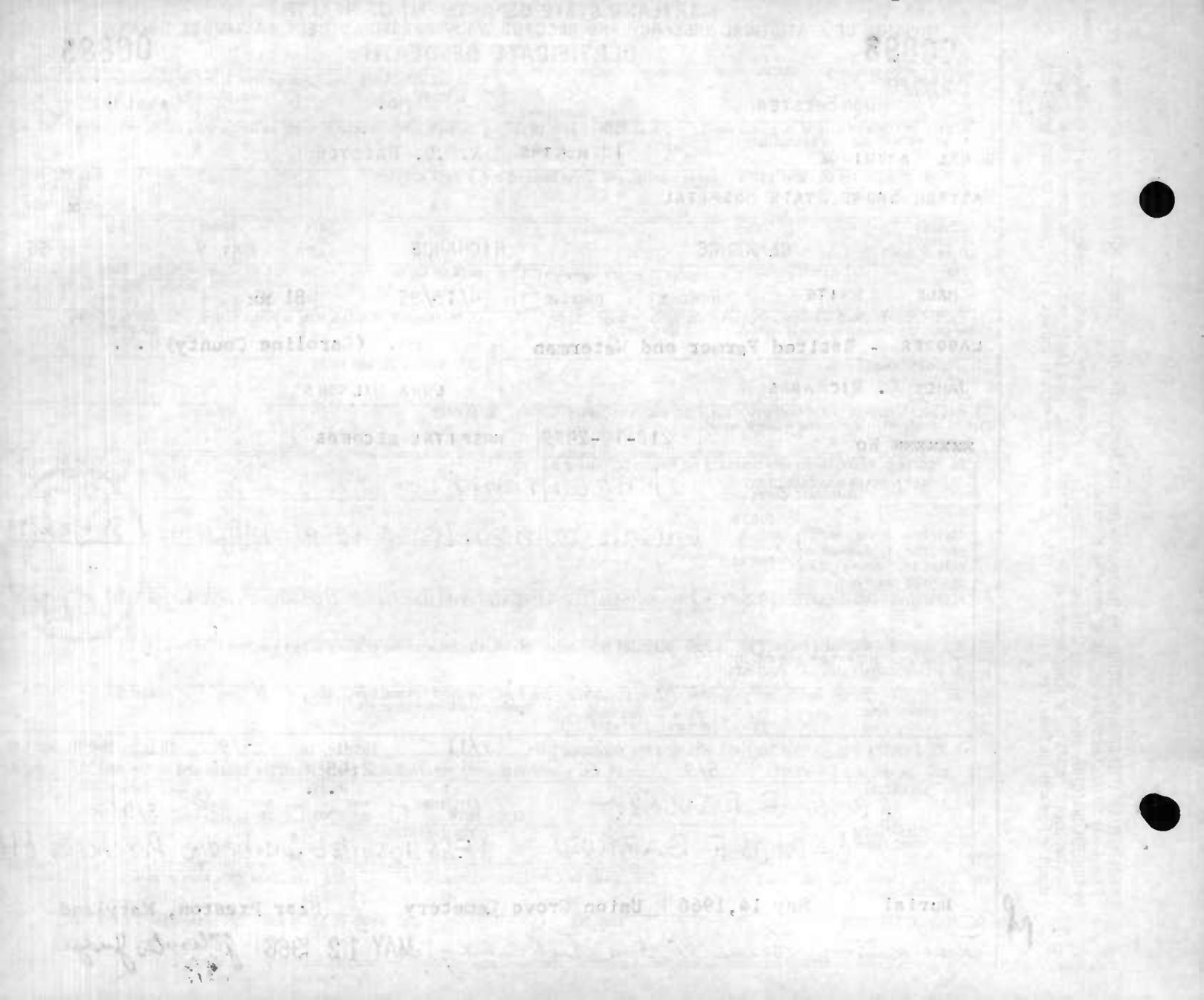
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1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
06893 CERTIFICATE OF DEATH 06885

1. PLACE OF DEATH a. COUNTY DORCHESTER			b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) RURAL CAMBRIDGE			c. LENGTH OF STAY IN lb 10 MONTHS											
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) EASTERN SHORE STATE HOSPITAL																	
3. NAME OF DECEASED (Type or print)			First CLARENCE	Middle	Last RICHARDS	4. DATE OF DEATH MAY 9	Month 19	Day 66									
5. SEX MALE		6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 4/13/85	9. AGE (in years last birthday) 81 86 yrs.	10. UNDER 1 YEAR Months 81	11. UNDER 24 HRS. Days 86	12. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER - Retired Farmer and Waterman			10b. KIND OF BUSINESS OR INDUSTRY INDUSTRY			11. BIRTHPLACE (County & State, or foreign country) Md. (Caroline County) U.S.											
13. FATHER'S NAME JAMES C. RICHARDS			14. MOTHER'S MAIDEN NAME FLORA WILKENS			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/> If yes give war or dates of service No			16. SOCIAL SECURITY NO. 218-14-2499 17. INFORMANT HOSPITAL RECORDS Address								
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia			DUE TO (b) Chronic bronchitis and emphysema			INTERVAL BETWEEN ONSET AND DEATH 2 days											
Ccnditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. 5020			DUE TO (c) 2 years														
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) White at work <input type="checkbox"/> Not White at work <input type="checkbox"/>			20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) at work			20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from 7/11 , 19 64 , to 5/9 , 19 66 , that (I) (we) last saw the deceased alive on 5/9 , 19 66 , and that death occurred at 2:45 P.M. from the causes and on the date stated above.						22a. SIGNATURE Carlos F Barroso			P.M.			22b. DATE SIGNED 5/9/66					
22c. PHYSICIAN'S NAME (Type) CARLOS F BARROSO			22d. ADDRESS ESS Hospital L. Cambridge Dorchester Md			23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF May 14, 1966			23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Union Grove Cemetery			23d. LOCATION (City, town or county) (State) Near Preston, Maryland		
24. FUNERAL DIRECTOR Flemington Funeral Home Federalsburg						25a. REC'D BY REGISTRAR MAY 12 1966			25b. REGISTRAR'S SIGNATURE Charles Judge								
B																	



1
M
FOR STATE
HEALTH DEPT.

To DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with your files.

To FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

06894 MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06886

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hurlock - Rural		c. LENGTH OF STAY IN 1b Life	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Near Elwood		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Leroy	Middle Robinson	4. DATE OF DEATH May 24 1966
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 15, 1914
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Day Laborer		10b. KIND OF BUSINESS OR INDUSTRY Farm	9. AGE (In years last birthday) 51 yrs.
11. BIRTHPLACE (State or foreign country) Dorchester Co., Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George Robinson		14. MOTHER'S MAIDEN NAME Manie Nichols	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 240-25-1772	17. INFORMANT Address Mrs. Elsie R. Lankford, Hurlock, Md., RFD
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion			
4201 DUE TO { Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>John Mace Jr.</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) John Mace Jr. M.D.		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF May 28, 1966	
23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Washington Cemetery		23d. LOCATION (City, town or county) Near Hurlock, Maryland	
24. FUNERAL DIRECTOR J. J. Frampton and Son, Federalsburg, Maryland		25a. REC'D BY REGISTRAR JUN 2 1966	
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

Perry

1
FOR STATE
HEALTH DEPT.

4

TO FUNERAL DIRECTOR: Please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, write "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO Health or its designated agent: prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06895 06887

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN 1b several weeks			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Cambridge Maryland Hospital		d. STREET ADDRESS None			
3. NAME OF DECEASED (Type or print) First WILLIAM Middle THOMAS Last RUARK		4. DATE OF DEATH Month May Day 7 Year 1966			
5. SEX Male 6. COLOR OR RACE White 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH Jan. 31, 1897 9. AGE (In years last birthday) 69 yrs.		10. IF UNDER 1 YEAR Months Deys Hours Min.			
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		11. BIRTHPLACE (State or foreign country) Dorchester Co., Md.			
10b. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waterman		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Thomas Levin Rurak		14. MOTHER'S MAIDEN NAME Alice Wallace			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unknown 17. INFORMANT Wallace Ruark, Dor. Co., Md. Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)					
INTERVAL BETWEEN ONSET AND DEATH 30 Mins.					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED White Not White at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE John Mace Jr. M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D.		DATE SIGNED 5/9/66	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		Address (Street, city, town, or county) Cambridge, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 9, 1966		22c. NAME OF CEMETERY OR CREMATORIAL Hosier Memorial Cemetery	
23. FUNERAL DIRECTOR LeCompte Funeral Service, Cambridge, Maryland		ADDRESS		24a. REC'D BY REGISTRAR MAY 12 1966	
				24b. REGISTRAR'S SIGNATURE Charles Judge	

1
M

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

06896

CERTIFICATE OF DEATH

06888

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) East New Market (Thompsonstown) Life				c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Thompsonstown						
d. STREET ADDRESS Thompsonstown				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print)		First Mary	Middle Matthew	Last Sampson	4. DATE OF DEATH May	Month May	Day 4	Year 19 66		
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH May 30, 1895		9. AGE (In years last birthday) 70 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. IF UNDER 24 HRS. Hours 0	13. IF UNDER 24 HRS. Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework			10b. KIND OF BUSINESS OR INDUSTRY Home			11. BIRTHPLACE (County & State, or foreign country) Dorchester County, Md.			12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Matthews				14. MOTHER'S MAIDEN NAME Julia Johnson						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 213-14-6755		17. INFORMANT Samuel J. Sampson, East New Market, Md. R.F.D.		Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]									INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>260X</i> Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)									<i>Cardiac Failure</i> <i>Diabetic Mellitus.</i> <i>Arteriosclerotic Heart Disease</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)									? 3 days 15 yrs	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
19		19		Federalsburg, Maryland						
21. I certify that (I) (this hospital) attended the deceased from 3-9 , 19 66 , to 5-4 , 19 66 , that (I) (we) last saw the deceased alive on 4-5 19 66 , and that death occurred at F&P M , from the causes and on the date stated above.									22b. DATE SIGNED 5-6-66	
22a. SIGNATURE <i>H. R. Trapnell</i>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					22b. DATE SIGNED 5-6-66	
22c. PHYSICIAN'S NAME (Type) H. R. Trapnell, M.D.				22d. ADDRESS Federalsburg, Maryland						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF May 7, 1966		23c. NAME OF CEMETERY OR CREMATORIAL Thompsonstown		23d. LOCATION (City, town or county) Near East New Market, Md.				
24. FUNERAL DIRECTOR <i>J. J. Frampton and Son, Federalsburg, Md.</i>		ADDRESS		25a. REC'D BY REGISTRAR DATE MAY 10 1956		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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To HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

M

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06897

CERTIFICATE OF DEATH

06889

1. PLACE OF DEATH

O. COUNTY

Dorchester

MARYLAND

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)

a. STATE

Maryland

b. COUNTY

Dorchester

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Rural - Cambridge

c. LENGTH OF STAY IN 1b

3 days

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

13 Eastern Shore State Hospital

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Secretary

07-1

d. STREET ADDRESS

e. IS RESIDENCE
ON A FARM?
YES NO

3. NAME OF
DECEASED
(Type or print)

First
Willard

Middle

Last
Saunders

4. DATE
OF
DEATH
05

Month

Day
13
Year
1966

S. SEX

Male

6. COLOR OR RACE

White

7. MARRIED

NEVER MARRIED

DIVORCED

8. DATE OF BIRTH

10-19-92

9. AGE (In years
last birthday)

72 yrs.

IF UNDER 1 YEAR

Months
Days
Hours
Min.

10a. USUAL OCCUPATION (Give kind of work done
during most of working life, even if retired)

UNKNOWN

10b. KIND OF BUSINESS OR
INDUSTRY

11. BIRTHPLACE (County & State, or foreign country)

Talbot Co.

12. CITIZEN OF WHAT
COUNTRY?

A.I.A.

13. FATHER'S NAME

Thomas Saunders

14. MOTHER'S MAIDEN NAME

Alice

15. WAS DECEASED EVER IN U.S. ARMED FORCES?

(Yes, no, or unknown) (If yes give war or dates of service)

UNKNOWN

16. SOCIAL SECURITY NO.

UNKNOWN

17. INFORMANT

Med. Records Address

INTERVAL BETWEEN
ONSET AND DEATH

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

465+ DUE TO

Conditions, if any, which gave
rise to immediate cause (a),
stating the underlying cause
lost. (b)

DUE TO
(c)

Pulmonary Embolism

0 MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING

OR CONTRIBUTING CAUSE OF DEATH
(If either, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

Cerebral Hemorrhage Accident

19. WAS AUTOPSY
PERFORMED?

YES NO

20c. TIME OF INJURY Month, Day, Year

Hour a.m.
p.m. 19

20d. INJURY OCCURRED

While Nat While
at work at work

20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (this hospital) attended the deceased from May 10, 1966 to May 13, 1966 that (we) last
saw the deceased alive on 5-13-1966, and that death occurred at 5:30 P.M. from causes and on the date stated above.

22a. SIGNATURE

James F Smith
22c. PHYSICIAN'S
(NAME/Type)

M.D. ATTENDING
PHYS. MED.
DIRECTOR STAFF
PHYS.

22b. DATE SIGNED

5-13-66

22d. ADDRESS

Eastern Shore State Hospital

23a. BURIAL, CREMATION,
REMOVAL (Specify)

General

23b. DATE THEREOF

5/15/66

23c. NAME OF CEMETERY OR CREMATORIUM

East New Market

23d. LOCATION (City or Town)

East New Market, Md.

(County) (State)

24. FUNERAL DIRECTOR

Keith S. Hollingsby

ADDRESS

East New Market

25a. REC'D BY REGISTRAR

MAY 18 1966

25b. REGISTRAR'S SIGNATURE

Charles Judge

2889

FL 24-30 FLORIDA

1023

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Dorchester		2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN 1b Life	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Cambridge Maryland Hospital		e. STREET ADDRESS Church Creek	
3. NAME OF DECEASED (Type or print) Calvin		First E.	Middle Stanley
4. DATE OF DEATH May 31 1966		Last May	Month 31
5. SEX Male		Day 1966	Year
6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH May 27, 1966
9. IF UNDER 1 YEAR Months 7		10. AGE (In years last birthday) yrs. 7	IF UNDER 24 HRS. Days 7
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Floyd Montgomery	
14. MOTHER'S MAIDEN NAME Esther Stanley		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give rank or date of service) No	
16. SOCIAL SECURITY NO. -----		17. INFORMANT Floyd Montgomery Church Creek	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) Pneumonia, acute tracheo-bronchitis		INTERVAL BETWEEN ONSET AND DEATH ?	
DUE TO 7630 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>John Mace Jr.</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) John Mace Jr. M.D.		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22e. BURIAL, CREMATION, REMOVAL (Specify) Burial		DATE SIGNED 6/7/66	
22b. DATE THEREOF 6/1/66		22c. NAME OF CEMETERY OR CREMATORIUM Aireys	
23. FUNERAL DIRECTOR Frederick C. St. Clair		22d. LOCATION (City, town, or county) Dorchester Co., Md.	
ADDRESS Cambridge, Md.		24a. REC'D BY REGISTRAR JUN 13 1966	
		24b. REGISTRAR'S SIGNATURE Charles Judge	

ABT

deach nōsio

elbow

Indigo (purple) & orange

yellow & white

soft, dry, & brownish, organ, black

purple

orange

green

yellow & white

white & yellow

black, dark, & brownish, white

white & yellow

Color	Material	Texture	Shape	Size	Weight	Odor	Flavor	Consistency	Temperature	Other
black	leather	smooth	oval	large	heavy	none	sweet	solid	cool	no smell
black	leather	smooth	oval	large	heavy	none	sweet	solid	cool	no smell
black	leather	smooth	oval	large	heavy	none	sweet	solid	cool	no smell
black	leather	smooth	oval	large	heavy	none	sweet	solid	cool	no smell

Color	Material	Texture	Shape	Size	Weight	Odor	Flavor	Consistency	Temperature	Other
black	leather	smooth	oval	large	heavy	none	sweet	solid	cool	no smell
black	leather	smooth	oval	large	heavy	none	sweet	solid	cool	no smell
black	leather	smooth	oval	large	heavy	none	sweet	solid	cool	no smell
black	leather	smooth	oval	large	heavy	none	sweet	solid	cool	no smell

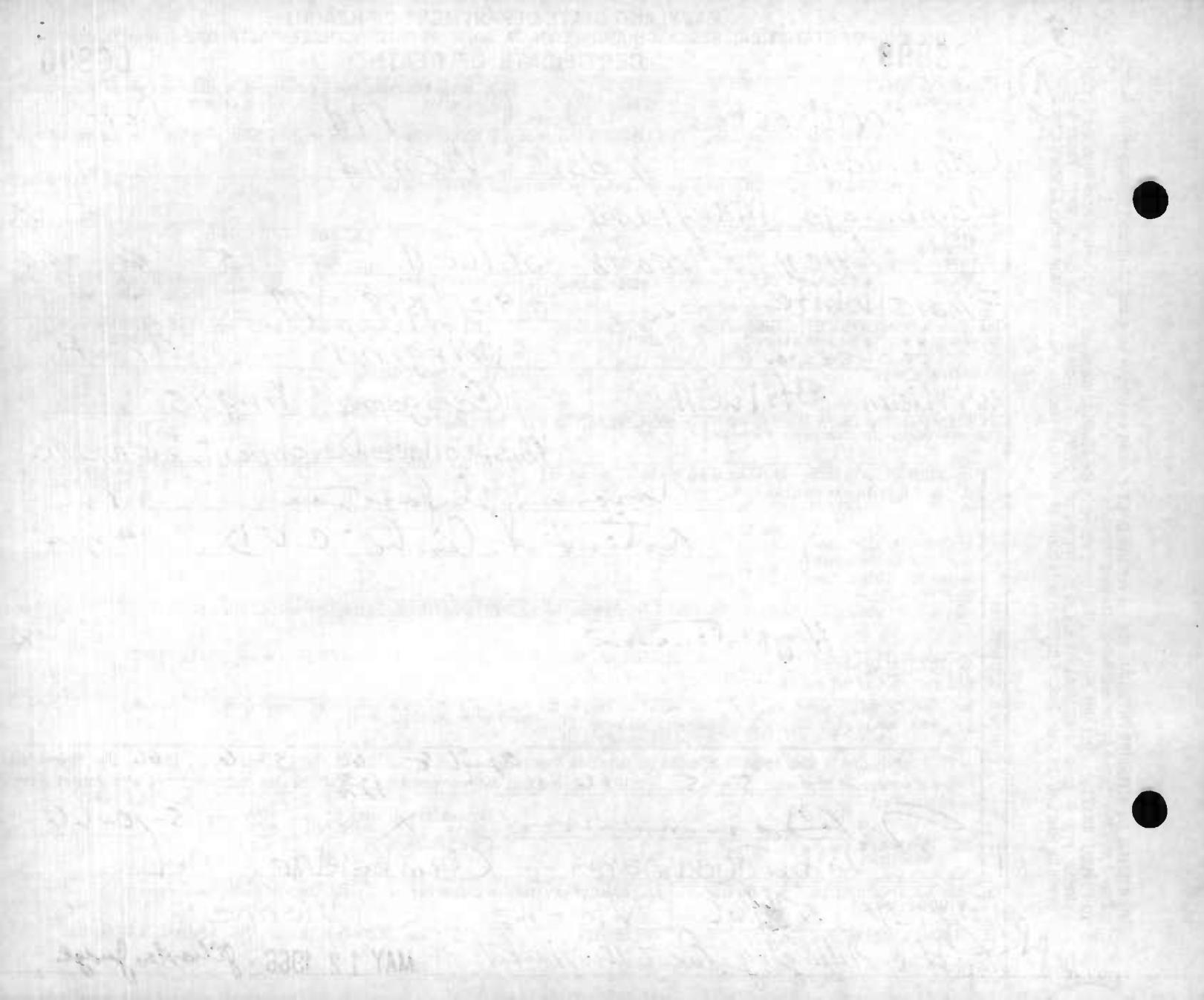
Color	Material	Texture	Shape	Size	Weight	Odor	Flavor	Consistency	Temperature	Other
black	leather	smooth	oval	large	heavy	none	sweet	solid	cool	no smell
black	leather	smooth	oval	large	heavy	none	sweet	solid	cool	no smell
black	leather	smooth	oval	large	heavy	none	sweet	solid	cool	no smell
black	leather	smooth	oval	large	heavy	none	sweet	solid	cool	no smell

Color	Material	Texture	Shape	Size	Weight	Odor	Flavor	Consistency	Temperature	Other
black	leather	smooth	oval	large	heavy	none	sweet	solid	cool	no smell
black	leather	smooth	oval	large	heavy	none	sweet	solid	cool	no smell
black	leather	smooth	oval	large	heavy	none	sweet	solid	cool	no smell
black	leather	smooth	oval	large	heavy	none	sweet	solid	cool	no smell

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND												06890								
CERTIFICATE OF DEATH																				
1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)																
Dorchester Maryland				a. STATE Md				b. COUNTY Dor												
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge				c. LENGTH OF STAY IN 1b 11 days				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Vienna				09-1								
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Cambridge Maryland				d. STREET ADDRESS				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>												
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH	Month	Day	Year												
Lucy Elizabeth Stilwell				Stilwell	5	6	1966													
5. SEX		6. COLOR, OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/21/1888	9. AGE (in years last birthday) 77 yrs.	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) Virginia	12. CITIZEN OF WHAT COUNTRY? U.S.A.	13. FATHER'S NAME William Stilwell	14. MOTHER'S MAIDEN NAME Georganna Angus	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/>	16. SOCIAL SECURITY NO.	17. INFORMANT Mrs. Wallace Davenport, Vienna, Md	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) Arteriosclerosis CVD (c) Hypertension	INTERVAL BETWEEN ONSET AND DEATH 1 hr	19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) Hyperension												20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury In Part I or Part II of Item 18.)	20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	21. I certify that (I) (this hospital) attended the deceased from April 8, 1966, to 5-6, 1966, that (I) (we) last saw the deceased alive on 5-5 1966, and that death occurred at 124 M, from the causes and on the date stated above.	22a. SIGNATURE Wilbur Davenport	22b. DATE SIGNED 5-10-66
22c. PHYSICIAN'S NAME (Type)	M.D.	ATTENDING PHYS.	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22d. ADDRESS Cambridge, Md	23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 5/10/66	23c. NAME OF CEMETERY OR CREMATORIAL Vienna	23d. LOCATION (City, town or county) Vienna	(State) Md										
24. FUNERAL DIRECTOR Baptist Tabernacle, East New Market	ADDRESS	25a. REC'D BY REGISTRAR MAY 12 1966	25b. REGISTRAR'S SIGNATURE Charles Judge																	
VR A15 (4) 15M 4-64	B6																			



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any page is necessary, please execute a certificate, writing the word "pending" in pencil in item 18. Give Pages 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-1 and 2. File pages 1 and 2 with the State Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

06900

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06891

1. PLACE OF DEATH

a. COUNTY

Dorchester

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Rural Hurlock

c. LENGTH OF STAY IN 1b

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

3. NAME OF
DECEASED
(Type or print)

First
Dallas

Middle
C.

Last
Thompson

5. SEX

Male white

6. COLOR OR RACE

7. MARRIED NEVER MARRIED
WIDOWED DIVORCED

8. DATE OF BIRTH

Sept 11, 1934

9. AGE (In years
last birthday)

31 yrs.

10. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Truck Driver - Becker Wholesale Food

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Delaware

13. FATHER'S NAME

Dallas H. Thompson

15. WAS DECEASED EVER IN U.S. ARMED FORCES?

No

16. SOCIAL SECURITY NO.

17. INFORMANT

(Yes, no, or unknown) (If yes give name and date of service)

14. MOTHER'S MAIDEN NAME

Edna M. Lowe

12. CITIZEN OF WHAT COUNTRY?

USA

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (e)

7230

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

DUE TO
(b)

DUE TO
(c)

Muscle injuries with
crushed chest and skull
fractures

INTERVAL BETWEEN
ONSET AND DEATH

20. EXTERNAL CAUSE WAS
PRIMARY OR CONTRIBUTING 21. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(e)

20a. CAUSE OF DEATH.

20c. TIME OF INJURY Month, Day, Year

Hour a.m. 9:40 — 5/19 1966

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

While at work

Not While at work

20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

Hurlock Dor

nd

21. I certify that I took charge of the remains described above, held an Autopsy , Inspection , Inquiry , and in my opinion death resulted from: Natural causes , Accident , Suicide , Homicide , Undetermined manner

ACTUAL
SIGNATURE

Pete W. Kieckert

CHIEF MEDICAL EXAMINER
M.D. ASSISTANT MEDICAL EXAMINER

DATE SIGNED

EXAMINER'S
NAME (Type)

Pete W. Rieckert

DEPUTY MEDICAL EXAMINER
M.D. Address (Street, city, town, or county)

5-19-66

22a. BURIAL, CREMATION,
REMOVAL (Specify)

22b. DATE THEREOF

22c. NAME OF CEMETERY OR CREMATORIUM

22d. LOCATION (City, town, or county)

(State)

23. FUNERAL DIRECTOR

ADDRESS

24a. REC'D BY REGISTRAR

24b. REGISTRAR'S SIGNATURE

29230

2.48 V. best among the
var. to Morgan's. D. 21.87
18 var. type
new species described by
Sosa in 1963. Inequalit. of teeth
all dorsal margin of maxilla

part - base of maxillary dentition - 2nd
and 3rd molar - 2nd molar - 2nd

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

06901

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06892

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 24 hours after death.

1. PLACE OF DEATH a. COUNTY Dorchester		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland		b. COUNTY Dorchester			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Cambridge		c. LENGTH OF STAY IN lb Minutes		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		d. STREET ADDRESS 204 High Street			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Seward-S-State Route 336				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) CHARLES HENRY WIER		First	Middle	Last	4. DATE OF DEATH May 2, 1966	Month	Day	Year	
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Mar. 31, 1905	9. AGE (In years last birthday) 61 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer		10b. KIND OF BUSINESS OR INDUSTRY County Roads		11. BIRTHPLACE (State or foreign country) Towson, Maryland		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME George Wier		14. MOTHER'S MAIDEN NAME Sally Robertson							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 218-16-7481		17. INFORMANT Mrs. C. Henry Wier, Cambridge, Maryland		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							INTERVAL BETWEEN ONSET AND DEATH INSTANT		
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bullet wound of brain									
976X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)									
DUE TO (b) (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.) Shot self with pistol.							
20c. TIME OF INJURY Hour a.m. 0:30 p.m. Month, Day, Year 5/2/66		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Blackwater river bridge, Dorchester, Md.		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <i>John Mace Jr.</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) Cambridge, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 4, 1966		22c. NAME OF CEMETERY OR CREMATORIUM Christ Church Cemetery		22d. LOCATION (City, town, or county) Cambridge, Maryland		(State)	
23. FUNERAL DIRECTOR LeCompte Funeral Service, Cambridge, Maryland		ADDRESS		24a. REC'D BY REGISTRAR MAY 4 1966		24b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			
VR A15ME SM 1/63									

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BALDWIN

TO 2001-10-10

INTERVIEWED

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CONTINUE

ACCUSED

RECORD

CONFIDENTIAL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED

DATE 2010 BY SP5 JES

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND												06893			
CERTIFICATE OF DEATH															
1. PLACE OF DEATH e. COUNTY Dorchester MARYLAND						2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico									
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hurlock, Maryland						c. LENGTH OF STAY IN 1b 6 days						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mardela Springs			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Belle Hacen Nursing Home						e. STREET ADDRESS Hurlock, Md.						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NOT <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)			First Louis	Middle	Last	4. DATE OF DEATH May 19th	Month	Day	Year						
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-30-1878	9. AGE (in years last birthday) 87 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	12. Hours	13. Months	14. Days	15. Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Rt. Farmer			10b. KIND OF BUSINESS OR INDUSTRY Farm	11. BIRTHPLACE (County & State, or foreign country) Maryland						12. CITIZEN OF WHAT COUNTRY? USA					
13. FATHER'S NAME William Wilson			14. MOTHER'S MAIDEN NAME Susan Goslee												
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO. -----	17. INFORMANT	Address Glen Wilson, Rhodesdale, Md.										
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure INTERVAL BETWEEN ONSET AND DEATH 4 days 4341 DUE TO Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) General debility 1 year DUE TO (c)															
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury In Part I or Part II of Item 18.)												
20c. TIME OF INJURY Month, Day, Year Hour a.m. 20d. INJURY OCCURRED p.m. 19 While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)									
21. I certify that (I) (this hospital) attended the deceased from May 14, 1966 to May 18, 1966 that (I) (we) last saw the deceased alive on May 18, 1966 , and that death occurred at 5:10 , from the causes and on the date stated above.															
22a. SIGNATURE Carlos F. Barroso						22b. DATE SIGNED 5/19/66									
22c. PHYSICIAN'S NAME (Type) Carlos F. Barroso						22d. ADDRESS Hurlock, Md.									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5-22-66		23c. NAME OF CEMETERY OR CREMATORIAL Mardela		23d. LOCATION (City, town or county) (State) Mardela Springs, Md.									
24. FUNERAL DIRECTOR Charles W. Marnell - Delmar, Del.		ADDRESS CHARLES W. MARNELL - DELMAR, DELAWARE		25a. REC'D BY REGISTRAR CHARLES JUDGE		25b. REGISTRAR'S SIGNATURE CHARLES JUDGE									
DATE MAY 23 1966															

REFERENCES

— 10 —

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND												CERTIFICATE OF DEATH		06894	
Item #9 Film #6317 1266 pa															
1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND												2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge												a. STATE Maryland	b. COUNTY Dorchester		
c. LENGTH OF STAY IN lb few years												c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		09-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Cambridge Maryland Hospital												d. STREET ADDRESS 8 Willis Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED First PRESTON Middle G. WOODLAND Last												4. DATE OF DEATH	Month	Day	Year
Type or print)												May 24,	19	66	
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 23, 1881	9. AGE (In years last birthday) 85 84 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days	Hours	Min.						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waterman			10b. KIND OF BUSINESS OR INDUSTRY Seafood			11. BIRTHPLACE (County & State, or foreign country) Dorchester Co., Md.			12. CITIZEN OF WHAT COUNTRY? USA						
13. FATHER'S NAME John Woodland						14. MOTHER'S MAIDEN NAME Not Known									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO. Unknown			17. INFORMANT Mrs. Hilda Gonce, Cambridge, Maryland			Address						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]												INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 5410 Duodenal ulcer with massive hemorrhage												5 days			
Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) Due to (c) Due to															
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)						
19									19						
21. I certify that (I) (this hospital) attended the deceased from May 18, 1966, to May 24, 1966, that (I) (we) last saw the deceased alive on May 23, 1966, and that death occurred at 34 M, from the causes and on the date stated above.												22b. DATE SIGNED 25 May 66			
22a. SIGNATURE Lewis M. Burdette, M.D.												22b. DATE SIGNED 25 May 66			
22c. PHYSICIAN'S NAME (Type) Lewis M. Burdette, MD												22d. ADDRESS City Office Bld'g., Cambridge, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF May 26, 1966			23c. NAME OF CEMETERY OR CREMATORY Dorchester Memorial Park			23d. LOCATION (City, town or county) Cambridge, Maryland			(State)			
24. FUNERAL DIRECTOR LeCompte Funeral Service, Cambridge, Maryland												25a. REC'D BY REGISTRAR DATE MAY 31 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	
VR AIS (4) 20M 1/65															

bifurc.

Understanding

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Digitized by srujanika@gmail.com

biochemical analysis, combination

卷之三

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Enriched chick